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ABSTRACT

This document contains the text of three hearings held in Vermont, Michigan, and Iowa which constitute part two of the Congressional hearings held to examine reauthorization of the Older Americans Act. Opening statements are included from Representatives Dale Kildee, Tom Sawyer, Fred Grandy, and Thomas Tauke. Testimony is provided from 55 witnesses representing: (1) several Area Agencies on Aging; (2) the Michigan Office of Services to the Aging; (3) the Vermont Office of Aging; (4) the Iowa State Department of Elder Affairs; (5) state and local agencies concerned with aging issues; (6) groups providing services to older adults, including Senior Citizens Services, Caregivers, American Association of Retired Persons, Amicare Home Health Services, Professional Nursing Service, Senior Center, the Information Center, Swiss Valley Farms, and the Alzheimer's Disease Association of Vermont; (7) the Food and Nutrition Service, United States Department of Agriculture; (8) United States Senator Tom Harkin; and (9) several residents of Vermont, Michigan, and Iowa. Witnesses provide evidence that the Older Americans Act is a vital program which serves the elderly well. Prepared statements, letters, and supplemental materials are included. (NB)

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REAUTHORIZATION HEARINGS ON THE OLDER AMERICANS ACT

Part 2

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARINGS HELD IN MONTPELIER, VT, MARCH 28, 1987; FLINT, MI, APRIL 11, 1987; AND ALGONA, IA, APRIL 24, 1987

Serial No. 100-19

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REAUTHORIZATION HEARINGS ON THE OLDER AMERICANS ACT

Part 2

SATURDAY, MARCH 28, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Montpelier, VT.

The subcommittee met, pursuant to notice, at 9:00 a.m., in Pavilion Auditorium, 109 State Street, Montpelier, Vermont, Hon. Dale Kildee presiding.

Members present: Representatives Kildee and Jeffords.

Staff present: Susan Wilhelm, Staff Director; Mary Jane Fiske, senior legislative associate; Mark Powden, minority labor staff director.

Mr. **Kildee**. The Subcommittee on Human Resources of the Committee on Education and Labor will come to order. We are gathered here in Vermont to hear testimony on reauthorization of the Older Americans Act. I will now turn the Chair over to my good friend and colleague from the State of Vermont.

[The opening statement of Hon. Dale Kildee follows:]

Opening Statement of Hon. Dale E. Kildee, a Representative in Congress From the State of Michigan

Older Americans Act programs provide the lifeline that enables the elderly to live independently in their communities. Whether it be transportation services, homemaker services, congregate or home-delivered meals, participating in senior center activities, or finding employment through the community service employment program, the Older Americans Act provides opportunities that enable the elderly to continue to be active participants in their communities.

The Older Americans Act and the programs it authorizes are among the most successful of any Federal programs currently operating. Although older persons may receive services under many other Federal programs, the act is the major vehicle for the organization and delivery of social services to this group. The fact that the act has been overwhelmingly reauthorized many times since 1965 attests to the strong bipartisan support it enjoys as well as to its effectiveness.

I have often stated that the role of the Federal Government is to promote, protect, defend, and enhance human dignity. Few Federal programs meet this challenge as effectively as the Older Americans Act.

I welcome all our witnesses and look forward to hearing your views as to how we can make this important legislation even more effective.

The House of Representatives is extremely fortunate to have a number of Members, on both sides of the aisle, who are recognized for their leadership and advocacy on behalf of the elderly. Jim Jeffords is one of those Members.

Mr. **Jeffords**. Thank you very much, Mr. Chairman. We welcome you to the State of Vermont. Our first witness this morning will be Joel Cook, Director of the Vermont Office on Aging. Please proceed.

STATEMENT OF JOEL COOK, DIRECTOR, VERMONT OFFICE ON AGING

Mr. Cook. Thank you, Mr. Jeffords.

1986 was a dramatic year for Vermont's Ombudsman Program and the residents of long-term care facilities. Area ombudsmen handled a record number of complaints. Important legislation affecting residents was passed. Recruitment and training of volunteer/assistant ombudsmen became a reality. The first printing of the Vermont Ombudsman Handbook became available for consumers. And significant involvement by consumers and residents in the Ombudsman Program increased.

The Ombudsman Program is mandated by the Older Americans Act. Ombudsman responsibilities simply put involve: individual advocacy, issue advocacy, disseminating information, and promoting community and consumer involvement both in the Ombudsman Program and long-term care. This report is organized into those four categories.

The Ombudsman Program consists of the State Ombudsman in the Vermont Office on Aging and five area ombudsmen, one in each Area Agency on Agency. The Vermont Office on Aging contracts for these ombudsman services with each Area Agency. Each Area Agency is a private nonprofit organization, and area ombudsmen are supervised employees of the Area Agency.

The State Ombudsman has responsibility for developing the statewide program in coordinating efforts, developing priorities, providing technical assistance, and monitoring local programs to insure they are in compliance with relevant law and programs policies.

Ombudsman services are free and confidential. Protecting resident's confidentiality is required by federal law, and breaching that confidentiality is allowable in only certain specific circumstances. That is with the informed consent of the client, and when ordered to by a court.

With regard to abuse and neglect of older persons, under federal law ombudsmen may choose to share that information with a law enforcement or public protective service agency. However, under Vermont law, ombudsmen are not required to share such information without the consent of the resident.

As to individual advocacy, ombudsmen investigate and resolve complaints made by or on behalf of the residents. Area ombudsmen handled 464 complaints in 1986, from 290 unduplicated complaints. Complainants often have more than one complaint concerning different aspects of long-term care.

As the attached charts to my written testimony indicate, most of these complaints involved patient care and patient rights. Roughly 40 percent involved nursing homes, 33 percent residential care homes, and the remainder involved unlicensed facilities, responsible parties, et cetera. Over 300 complaints were verified or substantially verified; roughly 100 were undetermined; and 43 were unjustified.

What is a complaint? The Ombudsman Program policies and procedures defines a complaint as (a) any reported problem with affects a resident or residents of a facility whether it be a nursing home, residential care home, illegally unlicensed facility or other institution concerning its operation, condition, personnel, care or treatment; (b) any infringement of a resident's rights, or misuse of resources by a guardian, power of attorney, friend or relative; and (c) any failure of an agency or service provider involved in the long-term care system to carry out its responsibilities as set down by law or the agency's policies.

For example, if two elderly residents of a nursing home attend a day care program are arriving unkempt and one with his urinary catheter improperly attached, and the program director has brought this to the facility's attention, but the problem continues. The director calls the area ombudsman who resolves the problem in discussions with the nursing home staff.

Or if an ombudsman visits a nursing home resident in response to a complaint. She is with the resident a few minutes when the facility social worker enters the room and states she wants to sit in on the meeting. This is clearly a violation of the resident's right to privacy. The ombudsman brings this to the facility administrator, who agrees that it will not happen again.

Or if the daughter of a nursing home resident asked the facility director to provide her mother, who is not able to sit up straight, with a reclining chair. The administrator told her he would look into it. A week later she has not heard anything. So she calls the area ombudsman for assistance who contacts the facility and the resident receives a reclining chair.

Or a resident tells the ombudsman that she has a guardian, and has asked the guardian to put $15,000 into a burial fund. The guardian has not done this, and the resident asks the ombudsman to help. The ombudsman calls the guardian who requests a formal letter. The ombudsman sends one on behalf of the resident, and the fund is established.

Ombudsmen receive many complaints which cannot be resolved without changes in law or regulation. Such problems affect large numbers of residents and their families and are usually complex.

In last year's ombudsman report, six issues were identified by the Ombudsman Program as affecting residents and their families the most. Those are Medicaid discrimination in admissions practices; lack of intermediate sanctions; lack of policy for holding beds for residents who must enter the hospital; inappropriate placements; inadequate staffing; and lack of mandated allowance for personal spending money for residential care home residents.

Of those six, four were addressed to some degree in 1986. One, a full range of intermediate sanctions were established by the legislature. When a facility has problems but revoking the license is not in the best interest of residents, one of several intermediate sanctions can be used to bring a facility into compliance. These include civil fines, suspending new admissions, transferring residents, and receivership.

Two, if a resident needs hospitalization and is a Medicaid recipient, Medicaid will not pay the nursing home for the resident's bed and also pay for the concurrent hospital stay. Most of the time this is not a problem, for nursing homes will hold a bed empty for a few days. If a facility does not, however, it creates a hardship for the resident who must move to another facility upon discharge from the hospital.

Now as part of the recently enacted Patients Bill of Rights, residents have the right to return to the first available bed in the nursing home they came from after hospitalization. This provision minimizes stress for the resident, and does not cost the nursing home or Medicaid extra money.

Three, ombudsmen receive complaints that people requiring nursing home care or residential care are inappropriately placed in illegally unlicensed facilities, that is facilities which should have a license. Those illegally unlicensed facilities too often receive referrals from providers and agencies.

A change in the facility licensing laws, attached to the intermediate sanctions bill, provides that agencies and professionals must not knowingly place a client in an illegally unlicensed facility. And if they have reason to believe a facility is operating illegally, they must report the facility to the licensing agency.

Four, most residential care homes allow their residents who are SSI recipients adequate personal spending money after paying their monthly bill to the home. Some homes, however, do not and a few take the residents' entire SSI check, leaving them no spending money for personal needs.

While this is a complex issue involving operators who claim that SSI payment levels are inadequate, leaving residents no or little spending money presents serious financial dilemmas for residents and affects their personal dignity.

The legislature passed a measure calling on the Agency of Human Services to promulgate regulations to assure residents of adequate personal spending money. The Agency of Human Services is developing a study of the issue.

One of the major pieces of legislation affecting residents was the Nursing Home Patients Bill of Rights. This bill did several things. It incorporated rights in federal regulation into the Vermont statute. It added four rights including a Medicaid recipient needing hospitalization.

It provided that residents receive a notice of their rights in clear and readable language, and that that same notice be posted in a conspicuous place in each facility. It provided that residents be informed of the facility's grievance procedure, and that residents be informed how to contact the ombudsman if they wish.

As to current issues, residents and advocates are still pressing for an increase in personal spending money for nursing home residents. Currently, Medicaid recipients are allowed $25 to meet personal needs. This amount has not changed in over ten years.

Staffing in nursing homes is one of the most frequent consumer complaints involving patient care. Inadequate training of nursing home aides is another frequent consumer complaint. And residential care home residents could benefit from the kind of bill of rights with notice and grievance provisions and information about ombudsmen that nursing home residents now have.

As to providing information, it takes two forms, to other agencies and to the public. The Older Americans Act does not specifically change ombudsmen to provide information to the public, but without doubt it is one of the most important things we can do. Consumers who have some understanding of the long-term care system have fewer problems later, and are better prepared to handle problems themselves.

This year the Ombudsman Program developed a memo of understanding with the Adult Protective Services Program, elderly abuse, to spell out among other things the proper referral process and guidelines for information sharing. A similar memo of understanding with SRS licensing, the Level IV homes, is in draft form and under discussion. Work will begin on a memo of understanding with the Department of Health in 1987.

The Ombudsman Program operates under strict confidentiality guidelines which prevents sharing of some information. But within that framework we can develop several vehicles for sharing information that regulatory agencies should be aware of.

The most important vehicle is a clear referral process so that complaints of a regulatory nature are referred with permission to the proper agency. If an ombudsman resolves a problem, the regulatory agency should know the problem existed and how it was resolved.

The Ombudsman Program continues to utilize various medica to educate consumers. The single most important informational development in 1986 was the Ombudsman Handbook. Written with input from Area Agencies on Aging, regulators and providers, the Handbook provides basic information to consumers anticipating entering the long-term care system.

The Handbook will be updated at least yearly. Program eligibility guidelines will be updated as needed by the use of inserts. The Handbook is available from area ombudsmen in the Area Agencies on Aging. They are primarily intended for residents, prospective residents and their families.

The State Ombudsman writes a monthly column for the Senior Herald on issues and concerns in long-term care. The State Ombudsman and area ombudsmen completed a total of 84 public information efforts including newspaper articles, radio shows, public service announcements, training and in-services.

Besides the above efforts, ombudsmen testified before several committees of the legislature on the legislation described in the previous section.

As outlined above, the primary responsibilities of the Ombudsman Program are individual advocacy and issue advocacy. But individual advocacy is more successful when ombudsmen can also enable and empower residents and other consumers to advocate for themselves. Issue advocacy is more successful when relevant parties join in discussion and coalitions.

Volunteers not only assist the area ombudsman, they represent a grass roots level involvement in the program. Volunteering or assisting in ombudsman work is not for everyone. It requires knowledge, patient, tact and persistence. But the difference one individual can make in the quality of residents' lives in enormous.

Volunteer/assistants in the Ombudsman Program are not intended to be friendly visitors. Rather by making regular contact with residents, a volunteer/assistant can provide information, explain a resident's rights, or encourage a resident to voice a grievance. The volunteer/assistant can follow up on problems to be sure the resident is satisfied.

Volunteer/assistants may choose to be certified to handle complaints and solve problems. In order to be certified, the volunteer/assistant must complete a trial period; take two initial days of training; pass a test; receive a good recommendation from the area ombudsman; and attend all regularly scheduled trainings. Volunteer/assistants are supervised by the local ombudsman and must refer certain complex problems, such as allegations of abuse, to the area ombudsman immediately.

The involvement of consumers and the community in the Ombudsman Program and long-term care began in 1985 with the development of the State Ombudsman Advisory Board. For 1986, efforts were begun around the state to develop local groups.

The Central Vermont Council on Aging ombudsman continues to work with the social worker at McFarland House on an executive resident council. The council has discussed how residents might have input on issues that affect them. They also are working on a video discussing what makes a good aide from the resident's point of view to be used for orientation.

The ombudsman in the Council on Aging for Southeastern Vermont began a long-term care support group for concerned consumers in the Springfield area. The group meets monthly to hear from knowledgeable persons in the long-term care field and discuss ways to promote effective and positive change.

The ombudsman in the Southwestern Vermont Area Agency on Aging began recruiting residents and providers for a local advisory board. This board would have input into the local program, be a forum for discussion, and a vehicle for promoting change and legislation.

In several instances, individual complaints have led to ombudsmen meeting with groups of local consumers. In such cases, the Ombudsman Program's policy is to encourage consumers to address problems themselves to the degree they can and then involve the ombudsman.

This entails giving the consumers information they need, such as regulations, which regulatory agency to contact, and the most effective ways of addressing complaints.

For example, ombudsmen have a form complainants can utilize to make sure their complaint is presented in a complete and organized fashion. In such cases, the ombudsmen often act as mediators as well as advocates working to improve dialogue between consumers and providers.

The State Ombudsman Advisory Board continues to meet at least quarterly, and board members have recently decided to try to meet more often. A slightly revised goal statement and list of board members is attached. More resident and consumer representation is needed, and this will be a priority in 1987.

In 1986, the board discussed the following issues. One, a survey of nursing home aides. The State Ombudsman decided to postpone the survey indefinitely because of perceived reluctance to participate on the part of a significant number of facilities.

Two, the Elderly Abuse law and facilities responsibilities to educate employees. The board recommended the Ombudsman Program work with the Adult Protective Services Program to provide and participate in such educational efforts which was done.

Three, a grant to provide training for nursing home staff on mental and emotional health problems of residents. The grant was completed and submitted to the Retirement Research Foundation and the Independence Fund. Unfortunately, it was rejected by both.

Four, a policy and procedure for utilizing volunteers in the Ombudsman Program. Five, the patient's bill of rights. The board suggested wording and organization for the notice to residents. And six, the board organization purpose in an effort to strengthen the board and increase its effectiveness. As to Alzheimer's disease, Alzheimer's disease affects the long-term care system dramatically, and the Ombudsman Program has been prominently involved in developing a statewide organization, the Alzheimer's Disease Association of Vermont.

The State Ombudsman was elected Chairman of the Board of ADAV and has contributed significant time to organizational and educational projects. The Vermont Office on Aging has contributed support staff time and other in-kind support such as mailings and copying to the organization. The Council on Aging for Southeastern Vermont also works closely with two local Alzheimer's support groups.

The Vermont Health Policy Corporation has a current project of holding statewide public discussions on the issues of critical and terminal care and the questions and dilemmas families, patients and care-givers often face. The project is called Taking Steps: Ethical Decisions for Living and Dying.

The State Ombudsman serves on the Advisory Board to the project, and is the discussion leader for discussions held in nursing homes. Seven discussions have been held in nursing homes by the end of 1986, and more are planned for 1987.

Thank you very much. I would be glad to answer any questions.

Mr. **Jeffords**. Thank you very much, Mr. Cook. Our next witness will be Ms. Pat Elmer, Executive Director of Vermont Associates for Training and Development, Inc. Please proceed.

STATEMENT OF PAT ELMER, EXECUTIVE DIRECTOR, VERMONT ASSOCIATES FOR TRAINING AND DEVELOPMENT, INC.

Ms. **Elmer**. Thank you very much. Representative Jeffords and Representative Kildee, I am Pat Elmer, Executive Director of Vermont Associates for Training and Development, Inc., a private nonprofit corporation. We design and operate employment and training programs specifically for the mature and older worker.

The members of this Employment Panel thank you for permitting us the opportunity to discuss the reauthorization of Title V of the Older Americans Act, the Senior Community Service Employment Project.

To establish the scope of this project in Vermont, it will be necessary for you to visualize as you look at any one of us on the panel, 6,249 citizens with employment and training concerns. In other words, collectively we represent 18,748 mature and older Vermonters who are eligible for the Title V project.

To meet this need, Vermont receives funding for merely 328 positions or an ability to serve hardly better than one percent. These 328 positions shared among our 14 counties gives us an average of 23 positions to meet the needs of more than 1,300 people.

We would recommend a modest increase in the number of positions funded. There is such a gap now that there is room to increase the number of positions funded in a fiscally responsible manner. To frame our discussion of the Title V project, we need to identify the context in which we are examining this reauthorization.

For example, what is happening in the business and commerce sector? Plants are cutting back, some closing, and some moving to other parts of the country. In industry, successful companies are retooling to orient themselves to automation and the changes in technology.

The relevance to our discussion is that many of those dislocated are in fact older workers. It appears that the generations which helped create the new technology are left behind by that very progress. There is a disproportionate number of older people in the declining industries like railroads, mining and agriculture, whereas in expanding industries their numbers are disproportionately small.

In the public sector, we are experiencing dwindling federal resources causing the cut-back if not elimination of a full range of programs from revenue sharing to housing and health care. All of our citizens are affected. The economic climate poses the problems of inflation and the higher costs of living.

Who suffers most? National statistics show that people over 65 are more than twice as likely to be poor than people under 65. It has been said that less money in old age is as certain as death and taxes. A grim picture of retirement income remaining fixed or decreasing while prices and medical expenses increase. If savings exist, they are quickly eroded. Thus, we see increasing pressures for this population to remain in or return to the labor force.

Now we are ready to look at the program. To describe it, I could quote the goals and objectives from the legislation, but instead let us challenge the program and describe it only by what it actually achieves and its relevance to the important social and economic conditions of our time. Regardless of which sector we look into, we see that all affect the older citizen and that the Title V project can improve each of these circumstances.

With regard to the conditions within business and industry, the Title V program provides training in new or updated job skills and comprehensive support and assistance for program participants to transition into the competitive labor force. The experimental project, Section 502(e), focuses on training to help older workers obtain employment in growth industries utilizing new technological skills.

With regard to the climate of the public sector, through the Senior Community Service Employment Project, older people can use their accumulated life skills to in fact upgrade existing community services and to develop new ones. The program enables communities to provide services that could not be offered through existing resources. A note of local interest, a full third of the positions we fund through the Community Service Project in Vermont are in education.

Regarding economic considerations, the Senior Community Service Employment Project fosters and promotes part-time work experience for disadvantaged persons who are 55 years or older. The project provides additional income on which the participants pay Social Security and applicable federal and state taxes, and it provides job opportunities in community service activities.

In summary, the Title V project has four very distinct objectives. That is community service, employment, training, and unsubsidized placement. It is no wonder that it has such a strong and loyal support from all quarters. Truly, it can be seen as having something for everyone.

What are the current issues then which threaten the stability of this effective and multi-faceted program? I see two major issues. The first is the per enrollee unit cost. The current level was set at $5,111 back in 1981 and it has not been adjusted since.

What has happened in the interim? Whether it be operating costs, training costs, or people costs such as the minimum wage increase, an issue facing other states which hit home in Vermont this year, you do not need me to tell you, it has all increased.

Our programs have survived to this point because we have learned to maximize our resources. We exceed our ten percent match requirements showing local community support. We serve more than our slot level. Vermont contractors have 159 percent utilization rate, and nationally the figure averages about 150 percent.

Most projects have found ways to offer their services to even more people, those one day under or one dollar over, the age and income guidelines. And we coordinate with other organizations to provide no cost and low cost services to our program participants.

We do not have enough money in our budget to provide all of the services required, so we have learned to broker. We have an excellent model of something that works. We are not asking for an increase, but only an appropriate adjustment for inflation and increased costs, so that we can start at least by July 1988 with a regained purchasing power for our project dollars.

Another recommendation would be to adjust the per enrolled unit cost to restore the one dollar value to our project resources.

The second issue relates to the administrative cap. The original limit was 15 percent set by Department of Labor regulations. That was a reasonable limit consistent with that of other programs such as the Job Training Partnership Act, and we all worked within it. However, in 1984 Congress lowered the amount in two stages, from 15 percent to 13.5 percent effective July 1986, and then to 12 percent effective July 1987.

We could summarize our argument on this issue on one phrase, rural projects do not have the opportunity to achieve the economies of scale. That is the jargon, but what is the particular significance of that here in Vermont?

Here as in other rural areas, we cannot serve the people by having one large office in the middle of the state. Our overhead is not used as in an urban setting, but rather needs to be stretched to support our rural service delivery network. We need to reach into the different areas. Our strategy would provide small local field offices and staff them with people 55 plus from those respective communities, people who know both the local needs and the existing services. We become part of the local team effort and thus are able to maximize our resources.

In rural America, it takes positive effort and action. The watchword is work cooperatively to maximize your resources. Urban projects by their very nature have the advantage, the economies of scale.

In a recent study, it was noted that 92 percent of the Title V projects currently have an administrative level that is less than 12 percent. If they are already at 12 percent, why did one-third indicate that a reduction of the ceiling to 12 percent would cause problems for them?

The study concludes that a possible explanation is that these local projects may expect their sponsors to require all projects under their jurisdiction to reduce administrative costs proportionately. And in our experience, that was the case with the initial reduction.

To see the significance, let us look at a local project. It could have a median federal funding level of $440,000 and a staff size of 2.5 people. What would be the impact of a one percent reduction on that project's administrative ceiling?

Let us say that it originally had an eight percent administrative level. Note that is well below the maximum. That would allow a total of $35,200 for all administrative costs. If that was reduced to a seven percent level or $30,800, the project just lost $4,400, a real cut in its administrative budget of 12.5 percent. That is the kind of cuts we are talking about in this reauthorization.

Many projects such as our own already sustained a cut of this proportion last July, and a similar cut as planned for this July would amount to a 25 percent reduction in thirteen months under the guise of a three percent reduction over the course of a two year period.

We would recommend an immediate freeze of the administrative cost cap at the current 13.5 percent level. Then through this reauthorization process, restore the cap to an equitable 15 percent level.

On behalf of the hundreds of mature and older workers in Vermont who benefit from the Senior Community Service Employment Project, we urge immediate action on these issues and thank you for your continued support.

[The prepared statement of Pat Elmer follows:]

PREPARED STATEMENT OF PAT ELMER, EXECUTIVE DIRECTOR, VERMONT ASSOCIATES FOR TRAINING AND DEVELOPMENT, INC.

Representative Jeffords and Representative Kildee:

I am Pat Elmer, Executive Director of Vermont Associates for Training and Development, Inc. - a private non-profit corporation; we design and operate employment and training programs specifically for the mature and older worker.

The members of this Employment Panel thank you for permitting us the opportunity to discuss the reauthorization of Title V of the Older Americans Act - The Senior Community Service Employment Project.

To establish the scope of this Project in Vermont, it will be necessary for you to visualize as you look at any one of us on the panel - 6,249 citizens with employment and training concerns. In other words, collectively we represent 18,748 mature and older Vermonters who are eligible for the Title V Project.

To meet this need Vermont receives funding for merely 328 positions - or an ability to serve hardly better than 1%. These 328 positions shared among our 14 counties gives us an average of 23 positions to meet the needs of more than 1,300 people.

Recommendation #1: A modest increase in the number of positions funded. There is such a gap now that there's room to increase the number of positions funded in a fiscally responsible manner.

To frame our discussion of the Title V Project, we need to identify the context in which we are examining this reauthorization.

. For example, what is happening in the Business and Commerce Sector? Plants are cutting back, some closing, and some moving to other parts of the country.

. In Industry, successful companies are retooling to orient themselves to automation and the changes in technology.

The relevance to our discussion: Many of those dislocated are in fact older workers. It appears that the generations which helped create the new technology are left behind by that very progress. There is a disproportionate number of older people in the declining indusries like railroads, mining and agriculture, whereas in expanding industries their numbers are disproportionately small.

. In the Public Sector we are experiencing dwindling federal resources causing the cut back if not elimination of a full range of programs from revenue sharing, to housing and health care.

All of our citizens are affected.

- The Economic Climate poses the problems of inflation and the higher costs of living.

Who suffers most? National statistics show that people over 65 are more than twice as likely to be poor than people under 65. It has been said that "Less money in old age is as certain as death and taxes." A grim picture; retirement income remains fixed or decreases, while prices and medical expenses increase. If savings exist, they are quickly eroded. Thus, we see increasing pressures for this population to remain in or return to the labor force.

Now, we are ready to look at the Program. To describe it I could quote the goals and objectives from the legislation, but instead let's challenge the Program and describe it only by what it actually achieves and its relevance to the important social and economic conditions of our time. Regardless of which sector we look into, we see that all affect the older citizen and that the Title V Project can improve each of these circumstances.

- With regard to the conditions within Business and Industry:

The Title V Program provides training in new or updated job skills and comprehensive support and assistance for program participants to transition into the competitive labor force.

The Experimental Project, Section 502 (e) focuses on training to help older workers obtain employment in growth industries or industries utilizing new technological skills.

. With regard to the climate of the Public Sector: Through the Senior Community Service Employment Project older people can use their accumulated life skills to, in fact, upgrade existing community services or develop new ones. The program enables communities to provide services that could not be offered through existing resources. A note of local interest, a full third of the positions we fund through the Community Service Project in Vermont, are in education.

. Regarding Economic considerations: The Senior Community Service Employment Project fosters and promotes part-time work experience for disadvantaged persons who are 55 years or older. The Project provides additional income on which the participants pay Social Security and applicable federal and state taxes, and it provides job opportunities in community service activities.

In summary, the title V Project has four very distinct objectives:

1. Community Service
2. Employment
3. Training
4. Unsubsidized Placement

It is no wonder that it has such a strong, loyal support from all quarters. Truly it can be seen as having "something for everyone".

What are the current issues which threaten the stability of this effective, multi-faceted program? I see two major issues.

1. The first is the per enrollee unit cost. The current level was set at $5111 in 1981 and has NOT been adjusted since.

What has happened in the interim? Whether it be operating costs, training costs, or people costs such as the minimum wage increase - an issue facing other states which hit home in Vermont this year - You do not need me to tell you. It has all increased.

Our programs have survived because we have learned to Maximize our Resources.

- We exeed our 10% match requirements showing local community support.
- We serve more than our slot level. Vermont contractors have 159% utilization rate and nationally the figure averages about 150%.
- Most projects have found ways to offer their services to even more people, e.g. those one day under or one dollar over, the age/income guidelines.
- We coordinate with other organizations to provide no cost/low cost services to our program participants.

We don't have enough money in our budget to provide all of the services required, so we have learned to broker. We have an excellent model of something that works.

We are not asking for an increase only an appropriate adjustment for inflation and increased costs, so we can start at least in July 1988 with a regained purchasing power for our project dollars.

Recommendation #2: Adjust the per enrollee unit cost to restore the $1 value to our project resources.

2. The second issue relates to the administrative cap. The original limit was 15% set by Department of Labor regulations. That was a reasonalble limit, consistent with that of other programs such as the Job Training Partnership Act, and we all worked within it. However, in 1984 Congress lowered the amount in two stages, from 15% to 13.5% effective July 1986 and then to 12% effective July 1987.

We could summarize our argument on this issue in one phrase - Rural projects don't have the opportunity to achieve the "economies of scale". That's the jargon, but what's the particular significance of this in Vermont?

Here, as in other rural areas, we cannot serve the people by having one large office in the middle of the state. Our overhead is not used as in an urban setting, but rather needs to be stretched to support our rural service delivery network. We need to reach into the different areas. Our strategy: provide small local field offices and staff them with people 55+ from those respective communities, people who know both the local needs and the existing services. We become part of the local team effort and thus are able to maximize our resources.

In rural America it takes positive effort and action; the watchword is - work cooperatively to maximize your resources. Urban projects by their very nature, have the advantage - "the economies of scale".

In a recent study it was noted that 92% of the Title V Projects currently have an administrative level that is less than 12%. If they are already at 12%, why then did one third indicate that a reduction of the ceiling to 12% would present problems for them? The study concludes that a possible explanation is that these local projects may expect their sponsors to require all projects under their jurisdiction to reduce administrative costs proportionately. And in our experience, that was the case with the initial reduction.

To see the significance, let's look at an average project. It would have a median Federal funding level of $440,000 and a staff size of 2.5 persons. What would be the impact of a 1% reduction in that project's administrative cost ceiling?

> Let's say it originally had an 8% administrative level - well below the maximum. That would allow a total of $35,200 for all administrative costs. If that was reduced to a 7% level, or

$30,800, the project just lost $4,400 - a real cut in its administrative budget of 12.5%. That is the kind of costs we are talking about in this reauthorization.

Many projects, such as our own, already sustained a cut of this proportion last July - a similar cut as planned for this July would amount to a 25% reduction in 13 months, under the guise jof 3% reduction over a two year period.

Recommendation #3: An immediate freeze of the administrative cost cap at the current 13.5% level. Then through this reauthorization process, restore the cap to 15%.

On behalf of the hundreds of mature and older workers in Vermont who benefit from the Senior Community Service Employment Project, we urge immediate action on these issues and thank you for your continued support.

Mr. **Jeffords.** Thank you very much for an excellent statement. Ms. Florence Memory, may we hear your testimony?

STATEMENT OF FLORENCE MEMORY, VERMONT CITIZEN

Ms. **Memory.** My name is Florence Memory. I am 85 years old and have been in this program for about six years. My job is with the Special Services Library for the visually impaired.

It consists of taking charge of the daily circulation of three departments, large print, tapes and records. Also adding up the monthly totals of each department. Also I have charge of sending out and crediting back the returns of all records going to Readers Digest and Guidepost patrons as well as several other magazine records.

My background is five years as a secretary and about forty years as an accountant. I was married many years ago, and in the first year of my marriage my husband was diagnosed as having tuberculosis and could not work for five years.

Consequently outside of the small amount of insurance he had before his illness, he could never again get insured because he only had one lung. He died several years ago. And when this job was offered to me, I had a total of $300 in the bank and my Social Security.

Also I have had three eye operations in the last fifteen years and no vision in my right eye. As you can imagine, this job has been a God sent to me, an alternative to welfare. Thank you very much.

Mr. **Jeffords.** Thank you. Our next witness is Joyce Ryder.

STATEMENT OF JOYCE RYDER, VERMONT CITIZEN

Ms. **Ryder.** My name is Joyce Ryder. I will be 57 years old this June. I started working under the Older Americans Act in July of 1985 through the Vermont Associates.

I have been able to go back to school and will be receiving my B.S. in Human Services this May. It was very important for me to have the training and job opportunity through Vermont Associates to achieve this goal. My work site has been a nonprofit human services agency called Umbrella.

Many other people are not aware of what it is like to be 55 or old and be without employment or enough financial security to pay the necessary costs of living. We want to work and we want a satisfactory wage.

I would like to give you a personal statement at this point. My husband is a mechanic, and I have done various types of work including being a store clerk, an inventory control clerk, and a collection clerk for a credit bureau.

In 1974, we rented our home and went to Florida in the fall. Our youngest son died in the spring of 1976, and we moved back to Vermont. And it was two months before my husband got a job in a garage. This job went fine for the next two years, and then the business was sold to a man from Massachusetts in July of 1978, and this man started letting the help go gradually.

Our other son was killed in a motorcycle accident in the fall of 1978. And my husband was fired in January of 1979, and he again was out of work for almost a year. He then worked for a farm equipment dealer, and it went out of business. He got a job at the

Datsun garage, and it went out of business. And this was over a couple of years time.

For four years, my husband was at home, and it was sad enough for him to face the deaths of our two sons without the loss of his self-esteem through unemployment.

In January of 1985, he went to the Vermont Associates, and they placed him at the bus garage at the middle school. The school was pleased with his work. And in June there was an opening for a custodian at the school, and my husband applied and got the job, and he will have worked there two years this July. We have our health insurance with this job which is a very important thing for us.

When I turned 55, I also went to the Vermont Associates and was placed at the Umbrella, a women's resource center. I gained valuable work skills in my job as a women's employment advocate. And at the present, I am applying for a job at the Northeast Mental Health Service. This was arranged through the Vermont Associates also.

I am sure that there are many Americans 55 years and older who could relate similar experiences. The opportunities for job training and employment we receive through the Vermont Associates is of utmost importance to many of we older Americans.

Mr. JEFFORDS. Thank you for two very moving statements. Both the Chairman and I are certainly very well aware of the importance of this program. Unfortunately, we have such little money available under this program that we do not help as many as we should.

The only good news is when you look at the demographics you see there is going to be a sharply declining work force as we go into the future. So, hopefully, there will be more jobs for our senior citizens.

Ms. RYDER. I would like to finish. I have a little more which I would like to finish at this point.

Mr. JEFFORDS. Sure. Go ahead.

Ms. RYDER. Certainly, the great American dream is not a reality for many of us. The opportunity to work and train for a job through the Older Americans Act is providing dignity and hope.

Living at a time in history where every place you turn the emphasis is on youth, the problems of the older person are not generally considered. However, as we look towards the future, we older people cannot be ignored. More and more people are living longer and the need to have meaningful jobs with sufficient pay will be mandatory for the American economy.

We are a nation with more resources than ever before in history. Yet people, older people, walk our streets without a place to live or enough food to eat, carrying their meager possessions while our government provides weapons for war in other countries with our money.

I asked our trusted public servants to weigh very carefully the facts and consider solutions that will be equitable to all. Certainly, the chance to work and train through the Older Americans Act and the Vermont Associates is one worthwhile method to empower people in this age bracket to reach for a more secure financial future which will include high self-esteem, dignity, and a better quality of life. Thank you.

[The prepared statement of Joyce A. Ryder follows:]

Prepared Statement of Joyce A. Ryder, Vermont Citizen

I will be fifty seven years old this June. I started working under the Older American Act in July of 1985 through the Vermont Associates.

I have been able to go back to school and will be receiving my B.S. in Human Services this May. It was very important for me to have the training and job opportunity through Vermont Associates to achieve this goal. My worksite has been a non profit Human Services agency called Umbrella.

Many other people are not aware what it is like to be fifty five or older and be without employment or enough financial security to pay the necessary costs of living. We want to work and we want a satisfactory wage.

Certainly the Great American Dream is not a reality for many of us. The opportunity to work and train for a job through the Older American Act is providing dignity and hope.

Living at a time in history where every place you turn emphasis is on youth, the problems of the olderperson are not generally considered. However as we look towards the future we older people cannot be ignored. More and more people are living longer and the need to have meaningful jobs with sufficient pay will be mandatory for the American economy.

We are a nation with more resources than ever before in history yet people, older people, walk our streets without a place to live or enough food to eat, carrying their meager possessions while our government provides weapons for war in other countries with our money.

I ask our trusted public servants to weigh very carefully the facts and consider solutions more equitable for all.

Certainly the chance to work and train through the Older American Act and the Vermont Associates is one worthwhile method to empower people in this age bracket to reach for a more secure financial future which will include high self esteem, dignity, and a better quality of life.

Mr. Jeffords. Pat, our committee also deals with the Job Training Partnership Act with the three percent set-aside for older workers.

Can you tell me how you are coordinating with that program, whether that has been of any great help to you, and just what is going on?

Ms. Elmer. Definitely. In Vermont, we have established excellent linkages with the Job Training Partnership Act. People within our eligible population have many needs. So by having the two programs, we are able in fact meet more of those needs.

Now the Job Training Partnership Act, as you know, has a focus on unsubsidized placements and training. So what we can do is help those people with job assistance, those who are ready to get into the private sector, so we can meet that type of need. And then we need to recognize the individuality of the Title V program, and that gives us the opportunity to provide work experience and deal with some of the longer term barriers that we need to address, like a low self-esteem, or no work history or job references.

So in fact, the two programs are very different. And by working them together, we can get a well-complemented program and meet more needs.

Mr. Jeffords. How did that coordination come about? What actually happened?

Ms. Elmer. We have a unique position here in Vermont, in that Vermont Associates is one of the contractors for the Title V program, but we also are the major contractor in the state for the Job Training Partnership Act three percent programs. So in fact by operating both programs ourselves, we can start to really ensure good coordination. And then we work with the other Title V sponsors to ensure that that continues across the state.

Mr. **Jeffords**. How many Title V contractors are there? Are you the only ones in the state?

Ms. **Elmer**. No, there are five. The state has its Title V contract, and they subcontract to the five Area Agencies on Aging and the Central Vermont Community Act. And then there is Green Thumb represented as well as the U.S. Forest Service. And the Forest Service runs a project themselves and they subcontract to Vermont's Department of Forests, Parks and Recreation.

Mr. **Jeffords**. Thank you. Mr. Chairman.

Mr. **Kildee**. Thank you, Jim.

Pat, you mentioned the $5111 limitation that is creating a burden. The Appropriations Committee recently brought to the House floor a supplemental appropriations bill which included a $10 million increase in Title V funding. I believe that the intent was to increase the number of slots by about 2,000 slots.

At this time, we in the Congress are debating whether or not to raise the minimum wage for everybody. But it would be appropriate if we were to raise the minimum wage that we also address ourselves to this cap of $5111.

Would that be helpful if we could raise that cap?

Ms. **Elmer**. Absolutely. Without getting any additional money to operate our program this year, Vermont faced the first of two steps and the increase of the minimum wage. And that caused a deficit for our own project, which as I just mentioned is only one of five in the state of $18,000, and that has not been recognized in any way through the legislation.

The other point is that it is great if you are going to put $10 million into the project to certainly increase the number of slots, but you have got to recognize that all of the costs have gone up, and we do not have ample funds to provide for the services that are being intended to be provided.

Mr. **Kildee**. Well, I really appreciate your bringing that to our attention because it is very timely. When I get back to Washington on Monday, I will be talking with the Appropriations Committee to see just what their intent was. We will find out whether they intended new slots or an increase in the wage or the stipend, and work with them at least for fiscal 1988 to see whether we can do something to raise that $5111. So I appreciate the timeliness of your testimony on that.

Ms. **Elmer**. Please feel free to have your staff get in touch with me, if I can help any further.

Mr. **Kildee**. Very good. I certainly will do that.

Another thing that has been brought to the attention of the subcommittee is that because of a lack of coordination, some Title V workers are facing a loss of benefits under other federal programs because of their Title V salaries.

The committee has been told that in some parts of the country in some instances Title V workers find out that they are no longer eligible for Section 8 housing, for example. In another case, we were informed of a widow who faced losing certain military pension benefits because of her participation in Title V.

Have you found that to be a problem at all here in Vermont?

Ms. **Elmer**. Definitely, and particularly the housing. If you look at someone who is 55 or over, and many of the people in our program are 65 and over, so looking at someone who is 65 who has been fortunate enough to get Section 8 housing or some type of subsidized housing.

They still have the health and the need to work, but they face losing that house if they try to get as our program is only minimum wage and twenty hours. Even with that type of small assistance that they go out they could lose their housing. So that issue needs to be looked at.

Mr. **Kildee**. So then the government should watch the right hand.

Ms. **Elmer**. Exactly. And also, this population that we are dealing with, and the older people particularly, have the work ethic. That if they had the health, they want to be out there working. So the wages that they are making in this program, they do not want to lose that house, because that is stability, and we can all understand that.

But if they could possibly take the job, it is not welfare, as Florence has mentioned. They are paying Social Security, and they are paying state and federal taxes. And they are out there many times getting off the program and getting into other jobs.

Mr. **Kildee**. I mentioned in my opening remarks that the government's job was to promote, protect, defend and enhance human dignity. You have certainly illustrated that this morning with the type of programs that you have, and the two other witnesses here. You certainly are doing a good job in doing just that.

Ms. **Elmer**. Well, it is interesting, because you helped to write the legislation, so you can share in that. Because truly, the program does have something for everyone. And it is unusual to have a program that can meet community service needs at the same time as economic needs and some of the other needs.

Mr. **Kildee**. I want to thank this panel. It has been very good. You know, very often not only do you enlighten our intellect with your information, but you give us the motivation to go back and try to make these programs work better. And we had both from this panel this morning. Thank you very, very much.

Ms. **Elmer**. Thank you.

Mr. **Kildee**. Next we have a panel on nutrition services consisting of Nona Estrin, Vermont Office on Aging; and Karen Kitzmiller, Vermont Office on Aging; Marty Levine, Central Vermont AAA; and Douglas Hall, Southwest Area Agency on Aging. Would you come forward, please.

STATEMENT OF NONA ESTRIN, NUTRITION PROGRAM CO-MANAGER, VERMONT OFFICE ON AGING

Ms. **Estrin**. My name is Nona Estrin, and I am the Nutrition Program Co-Manager at the Vermont Office on Aging. I think that we would like to give you a sense of the unique ways that Vermont has tailored Title III funds and USDA cash to provide senior meals in this small rural state. Before the other panel members speak, I want to just take a second to discuss two very important background factors.

The first is the extreme frugality under which these very popular programs now operate. Our unit costs for meals here are among the lowest anywhere. In some of the smaller towns, we have programs that are supported entirely by volunteer contributions and by the USDA reimbursement of 56 cents per meal.

Through careful management, and it is more than careful management, it is through very stringent management, and because individuals all over Vermont contribute generously of their time, money and other resources, our unit costs have fallen from $3.78 in 1978 to $3.08 last year in 1987. The $3.08 represents all costs associated with meals including program management. During that same period, I would like to note that the meal numbers rose steadily from 562,000 to nearly 900,000 a year.

Secondly, I would like to make the point that the need for these programs is keenly felt all over Vermont. It is growing surely as the demographics are changing. At the same time, as I am sure that you are well aware, everyone is looking for money. Federal revenue is gone and the carry-over gone, but still our costs go up.

Towns and individuals are very hard hit by funding raising and by appeals for help. Increased funding, both through the Act and also through the USDA, are absolutely essential if we are to keep abreast of the growing need and the increased costs.

Just a brief overview of the people we are serving. Home delivered meals. Approximately 50 percent of all meals that we serve are served to frail isolated people in their homes. It is 81 percent of these home delivered recipients who are women, 56 percent are over the age of 80, 59 percent live alone, and 63 percent live on less than $500 a month.

Congregate meals, which are meals that people take together in over 100 towns where isolated Vermonters can get together for meals and for companionship, 73 percent of these participants are women, 59 percent are over the age of 70, 62 percent live alone, and 51 percent of these people live on less than $500 a month.

Many of these people claim that the congregate meals program is their only social contact. It is their reason to get up in the morning, to get dressed, and to go somewhere where they know that a meal would not be put on without their help.

Doug Hall will speak to you next.

[The prepared statement of Nona Estrin follows:]

Office
on
Aging

Agency of Human Services, State of Vermont

103 South Main Street
Waterbury, Vermont 05676
Telephone (802) 241-2400

REAUTHORIZATION HEARING TESTIMONY

NUTRITION - SATURDAY, MARCH 28, 1987

I. Overview: Nona Estrin, Vermont Office on Aging

- o Focus of our remarks
- o Data - costs, numbers, history of same, profile of participants
- o Existing need, target, populations
- o Directions we are taking.

II. Close Up: Doug Hall, Southwestern Vermont AAA

- o Funding, community fund raising
- o Local control, doantions issue.

III. The Act Cannot Stand Alone: Nona Estrin, Vermont Office on Aging

- o USDA - relying on dollars
- o Need to know amount before FY starts
- o Numbers, towns, and variety of projects
- o Reliance on USDA for above.

IV. Close Up: Marty Levin, Central Vermont Council on Aging

- o Funding issues, Independence Fund, etc.

V. Home Delivered Meals and Targeting: Karen Kitzmiller, Vermont Office on Aging

Toll-free statewide "ACCESS FOR THE ELDERLY" telephone line 1-800-642-5119

I. My name is Nona Estrin, I am the Nutrition Program Co-Manager at the Vermont Office on Aging. We would like to give you a sense of the unique ways Vermont has tailored Title III funds and USDA cash to provide senior meals in our small rural state. Before the other panel members speak, I would like to stress two important background factors.

The first is the extreme frugality under which these very popular programs now operate. Our Unit costs for meals are among the lowest anywhere. In some smaller towns programs are supported entirely by volunteer contributions and the USDA reimbursement of $.56 per meal. Through careful management and because individuals all over Vermont contribute generously of their time, money, and other resources, our unit costs have fallen from $3.78 in 1978 to $3.08 in 1987. $3.08 represents all costs associated with the meal including program management. During that same period, meals numbers rose steadily from 562,000 to 889,000 a year.

Secondly, the need for these programs is keenly felt all over Vermont. It is growing as surely as the demographics are changing. At the same time everyone is looking for money. Federal revenue is gone, carry-over is gone. Still costs go up. Towns and individuals are hit hard by fund-raising and appeals for help. Increased funding, both through the Act, and through USDA are essential if we are to keep abreast of the growing need and increased costs.

I would like to give you a brief overview of the people we are serving. (See attachment: Vital Statistics From The Senior Meals Program.) Approximately 50% of all meals are served to frail, isolated people in their homes. 81% of these home-delivered meals recipients are women; 56% are over the age of 80, 59% live alone, and 63% live on less than $500.00 per month.

In over 100 towns, isolated Vermonters can get together for meals and companionship. 73% of these congregate participants are women, 59% are over age 70, 62% live alone, and 51% live on less than $500.00 per month.

I'd like to introduce Doug Hall who will speak to you about some directions we are taking.

II. Doug Hall, Southwestern Vermont Area Agency on Aging.

III. The Vermont Office on Aging has recently received a State grant from the Independence Fund to see if fifteen small communities which are currently without meal services for seniors can develop creative ways to provide local support for congregate and home-delivered meals. Clubs, churches, schools, and others will be encouraged to use USDA reimbursement of $.56 along with participant donations and volunteer efforts to establish a variety of self-supporting locally controlled meals programs. (Attachment: Booklet and Independence Fund Plans for 1987.)

There are already a score of small communities whose programs depend on this $.56 as their only secure cash resource. Therefore, Vermont depends entirely on a reliable and uncapped USDA subsidy for the growth of community supported meals programs.

Marty Levin, Central Vermont Council on Aging will talk to you about plans to develop programs in her area.

IV. Marty Levin, Central Vermont Council on Aging.

V. Home Delivered Meals and Targeting: Karen Kitzmiller, Vermont Office on Aging

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I.

TARGETING TO SPECIAL NEEDS

Because Vermont is small and rural and lacking in the traditional resources available to cities (well equipped senior centers, hospital, food service caterers, etc.) we have had to look at the federal regulations and figure out how we could bend them to meet the needs of Vermont's population.

We also believe that we need to adapt the guidelines in order to serve the hungry senior population rather than to make seniors conform to the ways of a congregate meal site.

Vermont has evolved 4 adaptations of the meals program that have served people well and stretched our resources.

Diner Program	($1.75 - 2.50)
Stock Our Shelves	($1.50)
Community Helpers	($2.00 - 2.50)
Community Contacts	($.56/meal)

We also have had small successes in working with the schools.

Oxbow Vocational School
Bristol
Thetford
Chester

We feel this has great potential.

HOME-DELIVERED MEALS

The Vermont Office on Aging has just completed a study to determine what is the unmet need for home-delivered meals.

4.7 meals per week per person.

Out of 250 towns, 144 had home-delivered meal service. 106 towns with out.

88% of Vermonters 60+ need help with meal preparation.

Beyond the people we're serving now, 690 more people need help with meals. If we were to serve them 7 meals per week and increase current service to 7 meals to all participants, $1,453,400 is the total amount of money we would need.

STATEMENT OF DOUGLAS HALL, SOUTHWESTERN VERMONT AREA AGENCY ON AGING

Mr. **Hall**. Good morning. My name is Douglas Hall, and I am the Director of the nutrition program for the Southwestern Vermont Agency on Aging, which provides services in Rutland and Bennington County. I have worked in that position for eight years.

Last year, we served 164,000 meals to elders in those two counties. We are one of five nutrition programs. I will speak very briefly about the subject of voluntary contributions by elders for meals versus charging a fee based on ability to pay. On this matter, I speak for the other nutrition programs in Vermont.

We are opposed to any changes in the Older Americans Act that would establish procedures for voluntary or mandatory cost sharing; in other words, fees by elders in the nutrition programs. We feel that it is important that donations be encouraged, but that they remain voluntary and private.

We believe that a fee schedule would alter for the worst the environment of meal sites and the home delivered meals program. We now serve elders of all income ranges, and therefore we enjoy a broad spectrum of support from communities.

Rather than generating additional income, a fee schedule we believe would place the nutrition program in a different light, and in the long run restrict our support by people of all ages and incomes. Also, a fee schedule would be difficult to administer and costly to administer with increasing paperwork and staff time.

Our program is funded primarily by two sources, federal funds and local fund. And through local fund raising, we go to the towns of Rutland and Bennington County each year and ask for town funds and are very successful with that effort.

Also as an agency and other agencies in the state do likewise, we do local fund raising. The meal sites and home delivered programs do local fund raising on their own. We feel that if there is any effort to increase local funds that there are other ways to do it and better ways to do it than a fee schedule.

And we feel that the voluntary and private donation system is the best one. Most people give what they are able to give. And we encourage that, and we stress its importance, but we also try to respect the dignity of the participants who are participating in the program, and we find that this works best. Thank you.

Mr. **Kildee**. Thank you.

Ms. **Estrin**. A brief note in regard to that issue of raising money. We found that a score of small towns in Vermont have emerged as wanting meals programs when there was no money to fund them. And because of the very small community nature of these towns and because of the good social networks in the communities, those are the communities that I had mentioned earlier who had been able to put on a meal with the cash resources of the sole 56 cents of USDA.

We feel that although you are here to look at reauthorization issues that we would like to point out that the Act does not stand alone, that the USDA subsidy is absolutely essential to many of our small communities who have that as their own cash resource.

We have just recently received a grant, a state grant, the Independence Fund grant to see whether or not fifteen communities who have not come forward asking if they could have the USDA resource and try to put something on on their own can be encouraged to put on such programs.

So in addition to the score of towns that we already have doing that, there is a possible fifteen more that would be absolutely dependent on this resource, and we urge you to consider that the Act as essential as it is does not stand alone. And that a USDA subsidy, which could be known in advance instead of what happened last year where we had the money possibly threatened after it had been spent, would be essential to these small communities who depend on it entirely.

Mr. **Kildee**. Thank you.

STATEMENT OF MARTY LEVIN, CENTRAL VERMONT COUNCIL ON AGING

Ms. **Levin**. Karen is going to speak very shortly in particular about the home delivery aspects of our nutrition program often known as Meals on Wheels which is a terribly, terribly important part of what we do, and we need it more and more.

I want to talk a little bit more about something that Nona has mentioned already, the home delivery sister program, the congregate meals service.

My colleagues from around the state and I believe that the impact that this program has on senior health and well-being can easily go unrecognized. It serves two functions. The obvious one being nutrition, the actual meals that are served at the sites. For many, many seniors eating at the site, the meal that they have there is really the one real meal of that day. We know that, and we go to a lot of trouble to make sure that there is as much nutrition in that meal and as much food value as we can possibly put into it.

What is not readily seen perhaps is the real importance of the human and social contact at the site. As Nona just mentioned, the typical congregate participant is apt to be a 70 or 75 year old woman usually widowed and living alone, and as Nona mentioned on Social Security income most commonly $500 or less and often much less than that.

Meeting at the site not alone but with others in a friendly and welcoming setting means an enormous amount to these seniors. The easing of daily loneliness which psychologists is the most painful and depressing emotion that any human being can experience, the opportunity for human interaction and recognition, someone saying hello and using their names and a welcoming staff can be as of much value to the seniors' emotional and mental health as the food is to their bodies.

The demographers are telling us over and over again that the years of our lives and of our old age are increasing. And for a woman, this tends to mean more years living alone and too often living lonely. The congregate meals program provides respite to that loneliness.

A couple of quick examples. A 76 year old woman in one of our smaller towns was called on a very frigid morning to let her know that the car that was supposed to pick her up to bring her to the site could not start. Rather than missing her site day, she walked three-quarters of a mile in fifteen below zero in order to get there. And she arrived, and she had a good time.

We have an elderly gentleman who arrives also walking and is often there at 7:30 waiting for the site manager to come and open the door, and he comes in and has a cup of coffee and often goes to sleep. He has no other place to go to be with people, again he lives alone.

We see the urgency of this need to be with others and the importance of the site to the elders' lives to fill this need over and over again.

I would like to speak briefly about funding also. I notice that each one of us thus far has talked about fund raising and about the energy that we put into doing that, and the energy that we put in to cut costs.

As was said, we have managed to reduce our costs greatly in the past five years. At the same time, the expenses to us have kept rising and the numbers of seniors needing services have kept rising equally. We have run very, very fast not to lose ground.

We have been so successful in fact that each time that we have been asked to reduce costs that some of us now believe that any time that more money is needed or more money saved that the most effective thing to do is to ask us to cut more costs and raise more money, and up to now we have done it.

Our staffing is skeletal and minimal. We have got towns who have lost their revenue sharing funds, and have requested for increased town funding along with many other organizations.

We have gone back and back again to community businesses and organizations for support, and wrack our brains to come up with fund raising schemes that will not take too much time away or add to much overtime to our professional responsibilities to our programs for seniors and our staff.

Many of our sites are in small towns, and probably most of them have one paid staff person overworked and usually underpaid. And senior volunteers, bless them, fill many, many gaps.

We have bent ourselves into pretzels in reducing costs as we have been asked to, and to keep serving the people who ask for our services. I think that I speak for most of us when I say that we cannot squeeze any more pennies out of the dollar. I think that we have got them all.

We feel that our backs financially speaking are against the wall. We want to be able to respond to an increasing need for services. And we want to be able to pay salaries to our staff that will allow them to stay with us. Often a clerk, for example, can be hired at our local hospital for a dollar an hour more than we are able to pay.

We need an increase of the USDA reimbursement, as little as that is. We need funding to be increased to allow us to keep up with costs and to answer the needs. We need the funding that is appropriated to be authorized, or is it the other way around, the funding that is authorized to be appropriated. We want to do the job that seniors need from us, and we want funds to do that with to do that appropriately.

I had not planned to say this, but I want to briefly endorse the woman on the panel previous to this who had mentioned that as you go back to Washington to do your work that you pay attention to the broader issues of the priorities of this government and where it spends money. And we think that it should be spent on human services.

Mr. **Kildee**. Thank you very much.

[The prepared statement of Marty Levin follows:]

CENTRAL VERMONT
COUNCIL ON AGING

18 South Main Street • Barre, Vermont 05641 • 802 479-0531

TESTIMONY TO THE HOUSE COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON HUMAN RESOURCES
ON THE
1987 REAUTHORIZATION OF THE OLDER AMERICAN ACT

Testimony of:
Marty Levin
Nutrition Director
Central Vermont Council On Aging

Karen Kitzmiller will speak shortly about the home delivery aspect of our nutrition program, a terribly important and increasingly needed service. I want to talk briefly about its sister program, the congregate meals service. My colleagues from around the State and I believe the impact this program has on senior health and well being can easily go unrecognized. It serves two functions. The obvious one is nutrition, and for many, many seniors attending the sites, the meal they have there is the one real meal of the day. We know that and we go to a lot of trouble to insure that it's good nutrition, that there's as much food value in that meal as possible.

Less readily seen is the real importance of the human and social contact at the site. The typical congregate participant is a 70 - 75 year old woman, widowed, living alone on a Social Security income of $500 or less a month, sometimes much less. The time spent at the site, not alone, but with others in a friendly and welcoming setting means an enormous amount to these seniors. The easing of the grind of daily loneliness, the opportunity for human interaction, recognition, and welcome by staff and friends at the site can be of as much value to the senior's emotional and mental health as the food is to their body. The demographers tell us over and over again that the years of our lives and of our "old age" are increasing, and for women, this tends to mean more years of living alone and too often, living lonely. The congregate meals program provides respite to that isolation and loneliness.

A few examples. A 76 year old woman in one of our smaller towns was called on a frigid morning to let her know that the car picking her up hadn't started yet. Rather than risk missing her site day, she walked 3/4 mile in 15 below zero weather to get there. One elderly gentleman in Barre arrives - again walking - at his site at 7:30 a.m. often waiting when the Site Manager gets there to open the door. He has no other place to go to be with people; again, he lives alone. We see the urgency of this need to be with others and the importance of the site to elders' lives over and over.

Now . . . as Nona Estrin told you a few minutes ago, we have managed to reduce our costs greatly in the past 5 years. Unfortunately at the same time, cost and expenses to us have kept rising and the numbers of seniors needing service equally. We've run very fast not to lose ground. We've been so successful, in fact, each time we've been asked to reduce costs, that we now believe there's a legend abroad that anytime more funds are needed or more money saved, the best thing to do is to C services to cut more costs and raise more money. Up to now we've done it. Our staffing is skeletal. We've gone back and back again to community businesses and organizations for support, racked our brains to come up with fundraising schemes that won't take too much time away or add too much overtime to our professional responsibilities to programs, staff, and seniors. Many, many of our sites in small Vermont towns have just one paid staff person, and she is overworked and underpaid. (Our senior volunteers, bless them, fill many gaps.) We've bent ourselves into pretzels reducing costs as we've been asked to. But I think I speak for all of us when I say we can't squeeze any more pennies out of a dollar. Our backs are against the wall, financially speaking, we're very tired, and we want to get on with our real work. We want to be able to respond to increasing need for services. We want to be able to pay salaries to our staff that will allow them to stay with us. We need the $ .59 USDA reimbursement. We need funding to be increased to keep up with costs. We want to do the job seniors need from us and we ask for funds to do that with.

STATEMENT OF KAREN KITZMILLER, VERMONT OFFICE ON AGING

Ms. **Kitzmiller**. My name is Karen Kitzmiller. I want to talk about two other issues. One is because Vermont is small and rural and lacking in traditional resources, we have had to look at the federal regulations for the meals program and figure out we could bend them to meet the needs of Vermont's population.

We also believe that we need to adapt the guidelines in order to serve the hungry senior population in our state rather than to make seniors conform to the congregate meal sites available.

We have come up with four adaptations, and I mention these to you as a plea that you keep the program flexible, so that we can continue to do these things.

We have advocates who go into small towns and find local seniors who need food desperately but would never attend a congregate site because they are socially unacceptable. They give them a voucher, and they can go into a local diner and redeem that voucher for an inexpensive meal that meets one-third of the USDA requirements. This program costs us substantially less, and it has enabled us to feed people that we otherwise could not serve.

We have also borrowed an idea from the WIC program, and we deliver grocery bags of food to people who are homebound but are mobile within their house. The grocery bags generally contain enough food for five meals that they can put together to form well-balanced meals. It is again a way that we can serve isolated homebound seniors.

In some of the cases where we have people who are homebound, we have developed a system we call community helpers. These people who are homebound might live twenty to thirty miles from an existing meal site. So we contract with their neighbors, so their neighbors cook and serve the meal to them in their home. It is substantially cheaper for us than delivering from a far away place. And again I encourage this system.

The last one we touched on before where we provide community contracts to towns where we have no funding but they want a meals program. And we give them 56 cents for every meal that they serve to a senior. The town provides the rent, the town provides the labor, and the two provides the outreach to bring the people to be there, and we give them the 56 cents in USDA reimbursement.

We urge you to keep the program flexibility, so that we can continue to do these things. And we believe that we are probably the only state in the country that has these four innovations.

We also began to work with the school system. And one of the most encouraging things that we are doing that we would like to see further is we are working with schools who package home delivered meals for seniors as an adjunct to their hot lunch program.

We have incorporated classes for students in community service, so that students too are involved in delivering meals and in visiting with the seniors, and tying the older people back into the school community.

We also have had some success in having vocational schools prepare hot lunches for seniors and invite the seniors in. And we in fact are paying the food budget for the vocational schools and they provide the labor.

The other thing that I want to mention is the increasing and awesome need for home delivered meals. We did a survey last October for one week of all of the people we served and all the meals that we served to them. During that one week last October, we served as the State of Vermont 6625 meals to 1416 different people. If you average that out, we served homebound people 4.7 meals a week.

We believe that in general people need seven hot meals a week. There is a substantial gap between that 4.7 meals and seven meals a week.

We also noted that Vermont has 250 towns of which we have service in 144 towns. That leaves 106 towns with no meal service, some of whom may not have elders who need help but some that we know do.

When we calculate all of this together and consider the fact that in a survey we did that 9.8 elders say that they need more meal help than they are currently given, it adds up that there are at least 690 people out in the boondocks of Vermont who are receiving no home meal service but who need them.

And if we wanted to serve them seven meals a week, and if we wanted to increase from 4.7 to seven meals a week and all of the people we currently serve, we come up with a staggering figure of $1,453,400 more that we need for that homebound meals program in Vermont.

And that is calculated at the unit rate of $3.25 a meal. That $3.25 includes the food, the labor, and the delivery, and absolutely every administrative cost associated with the meals. Thank you.

Mr. JEFFORDS. Thank you very much, all of you, for excellent testimony. And you do a good job I guess, at least from what you tell us.

Nutrition has been one of the areas where I have spent a great deal of my time in Congress—taking the lead from Senator Aikin before, recognizing the needs of rural Vermont, and the low per average income. You just answered the first question that I was going to ask, and that is what you really need to do the job.

In my own mind, it is so productive to fully fund the nutrition programs. And I think that million dollars plus that you are asking for would be well spent. One of the problems we have is that the savings that you generate from good nutrition and a good emotional environment for older people to be a part of is that it shows up as a savings somewhere else in the budget. It does not show up as savings associated with programs under our committee's jurisdiction.

We spend it, and it cuts down on medical costs, and it cuts down all sorts of other problems. But other programs get the credit for the savings, and we are the ones who get criticized for trying to spend more money when in reality, as we have seen with the WIC program in particular, our nutrition programs are very cost effective programs.

I was successful in getting the food stamp program cashed out for our state. And I would ask you if you could share with me what you do, or what do others do, when you find that people are not being supplemented by cash payments for food stamps? Is there any coordination that goes on to try to increase participation?

Even though we do better than the national average in the sense of participants, we are still fairly low for the elderly who are eligible for those payments.

Ms. **Estrin**. I cannot speak very thoroughly on this subject. Because our office made an attempt with a number of other agencies to try to address this problem about a year ago. And we found that the regulations themselves for food stamps were so very restrictive that every effort that we could undertake to try to bring people into the program sometimes were just completely undermined by the difficulty and the hurdles that the food stamp program itself presented.

To answer your question directly, when we find someone who does not have food stamps, and we find that person generally because an advocate visits and does intakes with our home delivered meals clients, and our congregate participants have an advocate available to them at the congregate site, when we find such a person, an advocate works with them to make those programs available in the simplest possible way.

But that simple way which involves the advocate helping them fill out forms and in many cases seeing that they get a ride to the appropriate office or seeing that someone certifies them in their home does not do it.

Because the regulations themselves require such a great deal of commitment on the part of the individual that it is often not worth it to them. And the actual food stamp benefit is so small that it does not work out to be worth the exposure. It may be a $15 gain a month.

I think that the cash-out aspect of getting cash is tremendously useful. But the net amount that people can recoup is so slow that it often does not merit the effort.

Mr. **Jeffords**. Well, we have automatic eligibility for SSI and programs like that.

Are you talking about people who are not on SSI then?

Ms. **Kitzmiller**. Yes.

Mr. **Jeffords**. Thank you.

Ms. **Levine**. It is also true by the way that the seniors tend not to ask. They tend to think of food stamps as something for someone who is really poor and in need.

It is very interesting. There was a survey done in central Vermont a couple of years ago, which I do not remember the percentage, but the great majority of the seniors surveyed did have income under poverty level, I mean that was it. And when asked if they were poor, they said no.

Mr. **Jeffords**. I understand that reluctance. And that was why we went to a cash-out, because it is so degrading for many to go into the store with food stamps. We have better participation than the national average, but obviously I would like to see 100 percent.

Mr. **Hall**. If I may speak briefly on that. When we get a referral for a home delivered meal in Rutland or Bennington County, the procedure is that we start meal delivery the next delivery day. Within ten days, one of our advocates visits the homebound person for several reasons.

The main reason is to see if they need any other service, if they are indeed eligible for any other benefit programs and to get a better look at their situation. And the advocates are knowledgeable and work with those programs daily.

We do encourage the use of food stamps in the meals program for donation purposes if people want to. So at least for the home delivered meals participants, people are being screened or given the opportunity to apply for the food stamp programs or other benefit programs.

Mr. **Jeffords**. Thank you. Mr. Kildee.

Mr. **Kildee**. Thank you, Jim. Vermont for a long time has had a great record on nutrition programs with Senator Aiken's effort. It is very interesting to hear this panel because you are trying to use some innovative approaches also not only to help people get the nutrition, but as much as possible to be very sensitive to their dignity. That is very important. .

I am very interested in seeing some of the innovative approaches that you have mentioned here this morning. We can get isolated in Washington. That is why it is good for me to get out to various places and see how you handle these programs to maximize the nutritional services, and also to protect human dignity.

Vermont has always had a great record on that. As I say, I belong to the other party. But when I was young, before I ever realized that I was going to get this far in politics, I knew that George Aiken was recognized throughout the country as being one of the great leaders in many areas. So we appreciate that.

And I will say this again. It is great to work with Jim. This plan that you have for Vermont is one that can perhaps be replicated elsewhere. We can look at your experience here to see how we can provide for those nutritional needs and at the same time be very, very sensitive to people's dignity.

Let me just ask one question. The Department of Agriculture has proposed revising the commodity reimbursement programs where states are reimbursed based upon the number of meals served the previous year. Under that proposal, they say that the states would know in advance how much money or reimbursement they would have received.

Could you comment on that proposal?

Ms. **Estrin**. We would be very sad in one respect. It would be an improvement to know what we were getting, but it would completely eliminate our ability to offer an expansion in towns that do not have programs or services at all. Because as I pointed out earlier, right now we have a grant from the Independence Fund which allows us to go into fifteen towns and put up signs, and get out and go to meetings, and talk with people and say look, is there some way that we can provide for the services for the people here on 56 cents that we can fund to you.

With the proposed change, we would not be able to do that, because the money would have been committed to those programs which have used it in the previous year.

Mr. **Kildee**. So you would have certainty, but you would also be locked in a bit?

Ms. **Estrin**. That is correct. It would really reduce the small cash assured piece that we use to generate innovative expansions, what we like to call innovative expansions. We would be sad about that.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. Thank you all for your very excellent help. We appreciate it.

Our next panel includes Patrick Flood, Vermont Office on Aging; and James Matteau, the Director of the Southeastern Area Agency on Aging; and Catherine Hutchins.

And if the following panel would like to come forward and sit in the front here, we would like to have you. Jerry Kirk, the Chair of the Governor's Elderly Advisory Committee. And then Dr. Lee Rathburn-McCuin, the Director of the Social Workers Program, University of Vermont. If you would like to come down, both of you, and sit in the front here.

Go right ahead whenever you are ready.

Mr. **Flood**. I am just going to introduce myself and my fellow panelists and then they are going to talk. My name is Patrick Flood, and I am a State Ombudsman, Office on Aging. On my right is Catherine Hutchins. Catherine is a nursing home resident at the McFarland House Nursing Home in Barre, and has been for about a year. And on my left is Jim Matteau, who is the Director of the Southeastern Vermont Council on Aging and a strong supporter of the Ombudsman Program. And I thought that we would ask Catherine to talk first.

STATEMENT OF CATHERINE HUTCHINS, VERMONT CITIZEN

Ms. **Hutchins**. I am Catherine Hutchins, a resident at the McFarland House in Barre. The Ombudsman Program was unknown to me, even though I had worked in hospitals almost forty years as a registered nurse, and the last five years working as a charge nurse in a nursing home.

Soon after my admission to the McFarland House in 1986, I learned about the Ombudsman Program. As I had a problem that I could not solve with the nursing home personnel, another resident gave me the address of Patrick Flood's office. I wrote to him, and within a week my problem was taken care of. Since using the program, I have been able to help other residents and their families to know how and where to get help. Some residents hesitate to complaint as they fear reprisal and being tagged as fussy and a complainer.

Another resident and myself were asked to go on TV to help inform the public as to what steps to take when they need to place anyone in a nursing home. Again this showed anyone where to go when having problems concerning a resident's care.

In February, we were video taped in the Home talking about the much needed increase on Medicaid residents' personal allowance of $25 per month.

In March, we were asked by Patrick Flood to go to the legislature to speak, again in regard to the personal allowance increase. Vermont Medicaid recipients have not had an increase since 1971.

Ombudsmen are the only people to help residents with large issues such as the person needs allowance or changes in the law.

Today many residents that are mentally clear are being placed with those that have mental problems. To me this seems unfair and should be changed by our state nursing home laws. If this practice cannot be stopped, then I suggest they be segregated on one wing.

Many Vermont elderly people do appreciate the time and effort given to us by our State Council on Aging, and Advisory Board, and the Ombudsman Program, and they like myself hope to see it renewed.

As a member of the Advisory Board I think many thanks go to Patrick Flood for his foresight on the needs for the elderly. Thank you.

Mr. JEFFORDS. Thank you, Catherine.

STATEMENT OF JAMES MATTEAU, DIRECTOR, COUNCIL ON AGING FOR SOUTHEASTERN VERMONT

Mr. MATTEAU. My name is James Matteau, and I am the Director of the Council on Aging for Southeastern Vermont, which is an Area Agency on Aging serving 46 towns. And I thank you for the opportunity to speak today.

I would like to make a few comments about the importance of the Ombudsman Program in our area, and I would also like to suggest a few ways that the reauthorization of the Older Americans Act can help us to address the problems and potential problems that we face.

There are 32 long-term care facilities in our area, and they are widely dispersed geographically. With one full-time ombudsman, even minimal presence in these facilities is difficult, and we are now in the process of developing a network of volunteers to help in that regard.

Our first volunteer assistant was recently certified and began working in Brattleboro, and we will be adding more volunteers as we grow. But ultimately, a program as vital as this one and so important to the well-being of our frailest elders cannot be overly reliant on volunteers if it is to be successful.

A regular and reliable presence in all of our area's facilities is essential to the operation of a trusted and effective program. Additional funding is needed to support the program at an adequate level.

I am pleased that when we consider the big picture and the status of long-term care facilities nationwide that Vermont seems to suffer few instances of extremely poor care. We also have a relatively low rate of institutionalization in Vermont which is attributable to a variety of reasons, but which raises for me the issue that our elders who are living in nursing homes may be on the average even frailer and more vulnerable than their typical counterparts nationwide.

We must have the ability and the clear authority to gain access to residents and their care records when we do encounter problems and if the facility's administration is not forthcoming with information.

The long-term care Ombudsman Program is clearly one of my agency's highest priorities, and we hope to see it grow considerably in the years ahead. Right now, however, it competes with other services for a share of limited funding under Title III-B.

The Ombudsman Program, as we have made it more visible in the community, is increasing its level of activity dramatically. In all of fiscal year 1986, we handled a total of 68 cases and complaints. Through January of this year, which is one-third of fiscal year 1987, we handled a total of 45. This is an annualized increase of 98 percent. And that is not enough. We want it to grow faster.

And it seems clear to me that we are not doing as much as we should simply because our staff resources are insufficient to respond to the referrals that a thorough marketing effort would generate. The Ombudsman Program needs a separate focus and identity in the Older Americans Act, and it needs adequate funding dedicated to that program alone to ensure its ability to operate effectively.

Finally, the ability of the Ombudsman Program to advocate freely and completely is crucial to its success. The Older Americans Act should specifically and completely prohibit any conflict of interest at any level of operation in the state.

It should also clear the way for Area Agencies to advocate with regard to needed legislation without being held back by the Office of Management and Budget's Circular A-122 or by restrictions that the Internal Revenue Service would place on the advocacy efforts of a tax-exempt organization.

In summary, the Council on Aging for Southeastern Vermont's long-term care Ombudsman Program needs the improvement and assistance that the following changes would provide.

One, establishing a separate title requiring each state to operate a State Long-Term Care Ombudsman Program that is completely free of conflicts of interest and that is mandated to advocate, including with regard to legislation, on behalf of long-term care facility residents. These requirements and protections should specifically include the sub-state programs as well.

Two, providing adequate and additional funding in order to ensure that the programs can operate effectively without competing for Title 3B resources that are already severely strained.

And three, mandating the ombudsman's access to residents in all facilities, including unlicensed facilities as may be defined by any state, access to clients who are transferred from a long-term care facility to a hospital, and access to records of long-term care facilities as needed and appropriate.

With these changes, the next few years will see an increase in the effectiveness of long-term care Ombudsman Programs nationwide and an increase in the quality of life for our frailest and most vulnerable citizens. Thank you.

[The prepared statement of James Matteau follows:]

COUNCIL ON AGING FOR SOUTHEASTERN VERMONT

Post Office Box 818 139 Main Street Brattleboro, Vermont 05301 Telephone (802) 257-0569

March 26, 1987

My name is James Matteau, and I'm the director of the Council on Aging for Southeastern Vermont, an Area Agency on Aging serving 46 towns. Thank you for the opportunity to speak today.

I would like to make just a few comments about the importance of the ombudsman program in our area, and I'll also suggest how the reauthorization of the Older Americans Act can address problems and potential problems that we face.

There are 32 long-term care facilities in our area, and they are widely dispersed geographically. With one full-time ombudsman, even minimal presence in these facilities is difficult, and we are now developing a network of volunteers to assist in that effort. Our first volunteer assistant was recently certified and began working in Brattleboro, and we will be adding more volunteers as we grow. But ultimately, a program that is so vital to the well-being of our frailest elders cannot be overly reliant on volunteers if it is to be successful. A regular, reliable presence in all of our area's facilities is essential to the operation of a trusted, effective program. Additional funding is needed to support the program at an adequate level.

I am pleased that, when considering "the big picture" and the status of long-term care facilities nationwide, Vermont seems to suffer few instances of extremely poor care. We also have a relatively low rate of institutionalization in Vermont, which raises for me the issue that our elders who are living in nursing homes may be, on the average, frailer than their typical counterparts elsewhere. We must have the ability and clear authority to gain access to residents and their care records when we do encounter problems and if the facility's administration is not forthcoming with information.

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The long-term care ombudsman program is clearly one of this agency's highest priorities, and we hope to see it grow considerably in the years ahead. Right now, however, it competes with other services for a share of limited funding under title IIIB. The ombudsman program, as we have made it more visible in the community, is increasing its level of activity dramatically. In all of FY1986, we handled a total of 68 cases and complaints. Through January of this year (1/3 of FY1987), we handled a total of 45 , an annualized increase of 98% It seems clear that we are not doing as much as we should, simply because our staff resources are insufficient to respond to the referrals that a thorough marketing effort would generate. The ombudsman program needs a separate focus and identity in the Older Americans Act, and it needs adequate funding, dedicated to that program alone, to ensure its ability to operate effectively.

Finally, the ability of the ombudsman program to advocate freely and completely is crucial to its success. The Older Americans Act should specifically and completely prohibit any conflict of interest at any level of operation in the state. It should also clear the way for Area Agencies to advocate with regard to needed legislation without being held back by the Office of Management and Budget's Circular A-122 or by restrictions that the Internal Revenue Service would place on the advocacy efforts of a tax-exempt organization.

In summary, the Council on Aging for Southeastern Vermont's long-term care ombudsman program needs the improvement and assistance that the following changes would provide:

1. Establishing a separate title requiring each state to operate a State Long Term Care Ombudsman program that is completely free of conflicts of interest and that is mandated to advocate, including with regard to legislation, on behalf of long-term care facility residents. These requirements and protections should specifically include the sub-state programs, as well;

2. Providing adequate, additional funding in order to ensure that the programs can operate effectively without competing for title 3B resources that are already severely strained; and

3. Mandating the ombudsman's access to residents in all facilities (including unlicensed facilities as may be defined by any state), access to clients who are transferred from a long-term care facility to a hospital, and access to records of long-term care facilities as needed and appropriate.

With these changes, the next few years will see an increase in the effectiveness of long-term care ombudsman programs nationwide and an increase in the quality of life for our frailest and most vulnerable citizens.

Thank you.

STATEMENT OF PATRICK FLOOD, LONG-TERM CARE OMBUDSMAN, VERMONT OFFICE ON AGING

Mr. **Flood**. Good morning, gentlemen. I do not know how familiar the committee is with the role of the ombudsman. And I would like to emphasize that to start with, because it colors everything else that I am going to say.

Our primary job is to act as advocates for people who live in nursing homes. I think that we are sometimes misperceived as just another arm of the Department of Health or a regulator, and we are not. We are advocates, and that is our primary job. And as Catherine was describing, we also try to get the residents themselves to advocate for themselves. The reason that I am bringing that up will become clear in a minute.

I would also like to just state that I know that your subcommittee has heard testimony from the National Association of State Ombudsmen, and I do not want to repeat everything that they have said.

But I think that it is interesting though, and I am sure that you are aware, that at the national level that there has been a lot of attention focused on the Ombudsman Program, its importance and its role, and rightfully so. Because I think that another fact that is not widely known is that one in four of us, those people in this room and at these tables, one in four of us will end up at a nursing home at some point in our lives, and that does not count all of the people who wind up in board and care homes.

So as to long-term care, in Vermont it may be five percent at any given time, five percent of the population. But in a year's time, the turnover rate is such that in fact seven to eight percent of the elderly population is in a nursing home in a year's time.

So I think that it is indeed time to stop and reevaluate the program and its priorities, and to ask Congress to give us the tools that we need to do the job that is so important.

Ombudsman responsibilities have grown since its inception when we were given primarily responsibility to investigate and resolve the problems on behalf of nursing home residents. In the ten years or so since that began, we have now had our responsibilities expanded to include all of the residents in board and care homes which in the State of Vermont is another 2,000 and basically doubles our client load.

Mr. **Jeffords**. Is that 2,000 beds?

Mr. **Flood**. Yes, 2,000 beds in board and care homes, and about 3,200 in nursing homes.

We have a tremendous responsibility to provide information. The general public knows nothing about long-term care, and they generally do not have a reason to until the time comes when the mother or father, or the wife or husband needs a good nursing home. And then they have to learn a tremendous amount of complex information very quickly, and they turn to us. So we have developed the capability to do that, but it is very time consuming.

Agencies, nursing homes, and community care homes even, legislators, you name it, turn to the Ombudsman Program as a resource for information and advice.

We now find ourselves being confronted with a specter of unlicensed facilities, some legal and some illegal, and those people are our clients if they have complaints.

And increasingly we find the Ombudsman Program being turned to for even increased responsibilities in terms of acute hospital care problems including DRGs and now home care.

It is also significant that the problems themselves have increased in complexity. We are not just talking about missing dentures any more. We are not just talking about patient care complaints. We are talking about complex financial problems. We are talking about complex guardianship and court problems. And we are talking about mental health problems.

So the Ombudsman Program has grown in its responsibilities and in the complexity of the work that we do. And so I would like to emphasize certain things. If we are going to act as advocates for this population, there are certain things that I think need to be addressed in the reauthorization process.

One is funding, and I am not going to beat a dead horse about it. I think that you understand the issue from what Jim has described. But it is interesting. Just the other day in speaking with Catherine that her nursing home, which is considered a good nursing home in the state, I said to her, Catherine, if I walk down the hallways, how many people up there do you think would have a problem or a complaint, and she said about 75 percent.

So if that is true in this state, then we should in fact be seeing something in the vicinity of 2600 or 2700 clients in nursing homes, and we can only see in a year's time 200 or 300.

So there is a great need out there that we just cannot meet. And as Jim pointed out, the rural nature of Vermont is such that the facilities are well spread. We spend too much time in fact on the road. We are turning to volunteers to help us to try and get that out-reach, but it is difficult. And travel time costs money too. In any case, there is a lot that we can do without more money, and that is what I want to emphasize.

One of the issues that is long overdue to be addressed at the federal level is access. There is no federal guarantee that an ombudsman can get into any nursing home or any community care home now. In fact, at least in the State of Vermont, it is not a serious problem at this time. But it is a problem that is sort of lurking under a tranquil surface.

Especially when it comes to board and care homes, a recalcitrant operator could literally stop us at the door, and we would have to go to court to get entrance. It could very interesting. I think that there are occasional incidents of even nursing home personnel sort of trying to hinder or modify our access to the residents.

And why it is important is that the residents themselves constantly being in an institutional setting are under certain well-intentioned intimidation. I mean they have to deal with that institutional setting all of the time. They are not likely to complain. They do not want attention focused on them, as Catherine pointed out.

It is important for them to know that there is somebody out there who has access to them at any time, and that they have access to the ombudsman and vice versa. And that should be free flowing access.

So I think that the federal government can do every Ombudsman Program and every long-term care resident a big favor by spelling access out very clearly.

Another major point that I think is long overdue in the Ombudsman Program, as Jim pointed out, is to spell out in the Act that Ombudsman Programs have the freedom to advocate on issues. I do not think that anyone questions our responsibility to advocate on behalf of individual residents.

And I think that the original intent of the Older Americans Act and the ombudsman section in that was not only that we advocate on behalf of individuals, but that from the information and the examples that we gain from dealing with individuals that we be free to recommend changes in the long-term care system.

And I do not want to sound too chauvinistic, but I think that ombudsman's role as I described being complex and far-reaching, that I think that we have a very unique perspective on the long-term care system as a whole. And even though we are turned to as a resource on sort of an individual basis, I think that we need to be free to point out the flaws in the system, because sometimes nobody knows it as well as we do.

The problem with this is twofold at least. One that you are probably familiar with are the restrictions or even a threat of restrictions brought by OMB Circular A-122, which is mentioned in lots of the documents that I have received in terms of freedom to advocate in general.

Another potential problem and often a problem is the fact that a lot of Ombudsman Programs are set in umbrella agencies, and you may or may not have heard about that. And it is a little difficult when you have a complaint or a problem against the agency down the hall to make that known. It is clearly a conflict of interest, as Jim was describing.

I think that what the federal government should do and that the Congress should do is address this problem and there are several ways to do it. One is simply to put language in the Older Americans Act saying that Ombudsman Program have not only the freedom but the responsibility to speak out on issues. I think that it can be done. The other possibility is simply to put in the law a prohibition on Ombudsman Programs being in umbrella agencies. There may be other approaches, but those are the two that come to mind right now.

In general, I would like to address the question of a broader mandate, as I mentioned earlier. There are people who think that the Ombudsman Program can and should be involved in home care complaints and acute hospital complaints.

Personally, I philosophically have no problem with that. I think that the ombudsmen that I work with are more than ready to do whatever we can do to help solve problems for any frail elderly people.

As you are probably going to guess, my objection is that if we are going to do that that we need a little more money. Because what we will object to is we will object to any additional responsibilities which detract from our ability to represent people like Catherine and the other residents.

The other major issues that have been brought up I will just mention briefly. Yes, training is a very important thing. There is no centralized general training for ombudsmen provided at any level at this point, or at least at the federal level. And it is needed, because nobody else knows how to do this job.

When you become an ombudsman, there is nobody down the hallway who teaches you how to do it. And I think that we need to develop that capability. It creates a more professional and capable program.

Beyond that, I would rather leave some time for questions than go into the other points that you have already heard and received from the National Association. Thank you.

[The prepared statement of Patrick Flood follows:]

PREPARED STATEMENT OF PATRICK FLOOD, LONG-TERM CARE OMBUDSMAN, VERMONT OFFICE ON AGING

Long Term Care Ombudsman Programs were created to resolve complaints for individual residents, and use that experience to suggest improvements in the long term care system. These are still vitally important functions and require an ever increasing body of knowledge, a tactful yet determined approach, and diligence.

As the long term care system grew, and grew more complex, so did the ombudsman's job.

From the initial mandate to resolve care problems in nursing homes, ombudsmen work has expanded to include thousands of board and care residents, people in unlicensed facilities, and recently requests to represent hospital patients, especially related to the prospective payment system. The compliants are as varied as the individuals making them.

More and more people turned to the onbudsman as a resource on long term care. Ombudsmen in Vermont are a resource, not only to residents, but to families, hospitals, agencies and legislators; even nursing home and board and care home staff regularly turn to the local ombudsman for information and advice. Ombudsmen provide a tremendous amount of information on long term care to the public, which is often bewildered by complexity of the system. Last year Vermont Ombudsmen answered over 1,100 individual requests for information and provided 84 public information efforts, including trainings, presentations, legislative testimony and newspaper, radio, and television reports.

This is important work, both to improve the quality of individuals lives, individuals who have lost so much, and to improve the system.

The growing scope and complexity of the ombudsman's role demands that we stop and determine priorities and how the program should be strengthened to meet the needs.

1. Adequate funding is important. We know we are unable to reach all the people who could benefit from our help. We are trying to address this by recruiting and training volunteers, empowering residents, and involving the rest of the community in long term care. A little more money would go a long way. But even without increased funding, thee are several changes which are overdue and which would help us help our clients.

2. Establish Access to Facilities, Residents, & Records

Access to facilities in Vermont is not a serious problem at present though it has been in the past. So far, our program's credibility and some dogged diplomacy have provided access without complications. However a major problem lurks under this tranquil surface if an operator, especially a board and care operator, chose to obstruct a visit.

A few intransigent operators look for ways to hinder or modify access. We need unrestricted access to ensure residents know who we are, how to contact us, and that they cannot be isolated.

3. Freedom to Advocate

Ombudsman interact with all the different parts of the long term care system, which, combined with hundreds of personal contacts with consumer problems, gives them a unique and broad perspective to point out systemic problems and suggest solutions.

Clearly, the Older Americans Act intended this to happen. Yet two major factors hinder this which can and should be addressed: OMB Circular A-122 and placement of the Ombudsman Program in a conflict of interest setting.

Ombudsman simply cannot resolve many individual complaints or problems without freedom to advocate for systemic change. The nursing home personal needs allowance is a good example. If the state administration opposes an increase, who represents the residents? The state ombudsman is constrained by being located in a State unit on Aging. The local ombudsmen programs are concerned about A-122, and even if they aren't, in a system like Vermont's the local ombudsmen are busy with individual client work and do not have time or the expertise to gather data and prepare testimony. Thus the one person most knowledgeable and able to represent the residents cannot. The residents not only go unrepresented, but in my opinion, the ombudsman is not doing the job the way it was intended.

Ombudsman programs must be free to make recommendations based on experience, and to empower and enable residents and consumer groups. There are at least two possible ways to accomplish this: explicit language in the act permitting issue advocacy, or a prohibition against placement of ombudsman programs in state umbrella agencies. Otherwise, residents are not truly represented.

4. Broader Mandate

Ombudsmen have demonstrated their ability to effectively handle all kinds of problems. There now appears to be a growing need to represent people in acute hospital and home health care settings. The Vermont Ombudsman Program has no philosophical objection to expanding to meet those needs. Unfortunately, at current funding levels, we cannot even properly meet our mandate to long term care residents, and we would strongly oppose any expansion that would detract from our work for the institutionalized elderly. If funding is available, we welcome any challenge to expand our efforts on behalf of other at-risk elderly people.

5. Other

We support mandated, federally supported training. The system we work in is very complex, and demands trained professionals. Certainly, training is necessary if program responsibilities expand.

Legal issues such as liability, and access to counsel are currently less serious issues here. Nonetheless we support the inclusion of such provisions.

We also support protections for those who report concerns or cooperate with investigations. Consumers, families, and staff are too often afraid to complain.

Ombudsmen represent our frailest elders, those without anyone to speak for them, often unable or afraid to speak for themselves. In spite of good work in the past, the system expands and grows more complex. We are ready to work harder, help more residents, take on more challenges. We are asking for the tools.

Mr. **Jeffords**. Thank you. It was fine testimony. As I mentioned earlier, I was one of those who helped set the program nationally, so I have a deep interest in this. And I could probably spend the rest of the morning asking you questions about it.

Mr. **Flood**. We are free.

Mr. **Jeffords**. I am sure that we will correspond or be in touch with you on some additional matters of interest. One of the dilemmas that we face is that the harder you work, the greater the needs you identify. And, if you have limited funds, then you have the very difficult question of how to take care of the needs that you identify and, at the same time, improve the funding for those who disclose the needs. And it is a tough dilemma. Obviously, we would like to have more money, and we will keep fighting for it. That is all that I can say.

I am interested in how you are structured. You have a great $20,000, I guess, that comes from the Ombudsman Program, and I would hope that all of you are not living on that.

Mr. **Flood**. No, we do a little better than that. Our structure is somewhat different. There is a State Ombudsmen, myself, in the State Office on Aging. Each of the five Area Agencies maintains a paraprofessional in fact, an ombudsman, at the local level full-time. So they contribute some of their Title III funds to that, and they receive some money through the state through Title IV advocacy assistance monies. So in fact, we spend in this state about $120,000 on our Ombudsman Program.

Mr. **Jeffords**. And so you take that from the other Title III funds and whatever and utilize that money which could otherwise be used for services which is my point.

Mr. **Flood**. Well, if they were not giving it to us, they would be using it for something else.

Mr. **Jeffords**. Well, I'll see if I can do something about that.

Can you give me a general idea of the kind of complaints. Nationally, there has been a lot of attention based upon elderly abuse.

Is that a problem here?

Mr. **Flood**. I was thinking about that this morning on my way over here. In fact, last year—and I am trying to find the page in here that talks about the kind of complaints that we had—in fact, abuse and neglect was one of the most commonly reported complaints.

Mr. **Jeffords**. I am sorry, abuse and what?

Mr. **Flood**. And neglect.

Mr. **Jeffords**. And neglect, yes.

Mr. **Flood**. We try and put those together, as they tend to be the same thing. They tend to be really bad cases of either one. There were 46 that we had last year out of 464 complaints. But when you break it down, there is only one or two other categories. Patient care was 102 complaints. So the next most common one that we get is abuse and neglect.

It is odd for that to be the most common kind of complaint when you think of all of these other things that go on. There is no way to explain why people complain about that and not complain about certain other things, except that it is a situation that is so intolerable that they are no longer afraid to complain, and are afraid not to complain. And that is not all in nursing homes, mind you. This is also in board and care homes and some unlicensed facilities.

Mr. **Jeffords**. You have 2,000 beds in board and care places. It must be difficult to deal with.

What is the average size of a board and care place?

Mr. **Flood**. They say about 10 or 12. They run from 8 to 45. But there are roughly 140 of those facilities in the state. You can see the coverage problem in trying to get out to them all. We have 45 nursing homes, 140 community care homes, and five ombudsmen, that is forty apiece. That is one a week.

Mr. **Jeffords**. And they are spread all over the state?

Mr. **Flood**. They definitely are. That is a real travel problem. It is very time consuming.

Mr. **Jeffords**. Mr. Kildee.

Mr. **Kildee**. Thank you, Jim.

You mentioned, Patrick, and we have heard from others also, that we should have more specific language giving the ombudsman access to the facilities and to the records and documents.

Have you found any problem here in Vermont after you get access to the facility to have access to the records and documents that you might need in order to assist the individual? Are you aware of any other problems?

Mr. **Flood**. Yes, we are definitely aware of them. I am just trying to think of how to answer your question in the best way. We do have a problem getting access to records. I am not sure exactly why, except it is something that we have begun to do now in the past few years. We have been a tad more aggressive maybe and had not been in the past.

But we meet difficulties. And in fact, we have to say things like okay, we will be back with a lawyer. I mean it has happened a few times, and it is unfortunate. Most facilities off the top they cooperate. But we do have problems, and access to records would be a big plus.

Mr. **Kildee**. What reasons do they usually give you when they deny you access to the records?

Mr. **Flood**. They cite administrative reasons. They cite that their lawyers say not to give out a record to anybody. You know, policy. I cannot think of any other reasons that they have ever given us. They just say our lawyer advises us not to show you that record.

Mr. **Kildee**. Do you feel then that if we could address that in legislation, spelling out the guidelines and your right to have access, that it would help you in discharging your responsibilities?

Mr. **Flood**. I think tremendously. Because we operate on the premise that we are not going for a record anyway unless the resident gives us written permission, but even that gets challenged.

Mr. **Kildee**. We would be concerned with the right to privacy of the individual.

Mr. **Flood**. Absolutely.

Mr. **Kildee**. We would have to respect their choice in that also.

You mentioned, Mr. Matteau, the A-122 document by OMB. Could you elaborate for us as to how this would limit you in your advocacy if we did not address ourselves to that in the legislation.

Mr. **Matteau**. Yes. I think that just about any Area Agency lives under a fear right now. We are walking on somewhat of a tight rope. We have a congressional mandate to advocate and to comment on public actions affecting elders in general and in our service areas in particular, and we do that.

And it is my understanding that that legislative mandate takes precedence over the Office of Management and Budget's administrative regulation, but I am always looking over my shoulder and it is not comfortable.

And the reason is I do not mind at all being told that I should not be criticizing. Because as soon as the government or any official pulls out the Office of Management and Budget's regulation and tells me that I should not be advocating for something, I know that I am not target. So in some ways, it can be a bell ringing.

But the risk is and what I have to always be very cautious about is am I going to because of my lack of jurisprudence going to put my agency in a position of losing funding down the road. And that is going to hurt the people that I am trying to advocate on behalf of, and it would be totally self-destructive. That is a fear that we work under every day, and it should not be there and it should specifically be removed.

And another one which I am only recently becoming aware of, because the agency that I work for is the only one of the five Area Agencies in Vermont that is not a 501(c)(3) tax exempt organization and so this was not in my mind, but I recently learned that the IRS regulations which prohibit to the extent to which one of those agencies can advocate could in fact result in getting hit with the other end of the hammer. And they could really be burned if they were found to be not adequately accounting for every dollar spent, to the extent of one Area Agency having to account for a breakout of all of the costs of producing their annual reports, because some of those reports without any advocacy or information attached were mailed to state legislators.

So they are now backing out on financial information to document that in fact does not place them in violation of IRS lobbying activities. It is a lot of work. It is a lot of work, but they do not dare not do it.

Mr. Kildee. Ms. Hutchins, a question to you.

Does the fact that the Office of Ombudsman exists give some peace of mind to people in these institutions even though they might not have to call that ombudsman? In your experience, does the fact that they know that they can call give some peace of mind to the people in the home where you reside?

Ms. Hutchins. I would say that it does give peace of mind to everyone who learns about it.

Mr. Kildee. Just the fact that they know they can have someone who is an advocate for them?

Ms. Hutchins. There seems to be many people, many residents and families who do not seem to know anything about it.

Mr. Kildee. So we should try then to spread the word more about it?

Ms. Hutchins. Right.

Mr. Kildee. Thank you very much.

Mr. Jeffords. Thank you all for very, very helpful testimony. And I will be back in touch with you, to make sure that I try to do the best I can to help you do the job.

The next witness is Jerry Kirk, Chairman of the Governor's Elderly Advisory Committee. And then our witness after that will be Dr. Lee Rathbone-McCuan, the Director of the Social Workers Program, the University of Vermont. If you would come forward.

And then the next panel will be Jean Dedam, the Director of the Northeast Area Agency on Aging; and Mara Coven, the Director of the Champlain Valley Area Agency on Aging; and Craig Hammond, the Director of the Central Vermont Area Agency on Aging.

Jerry, it is good to have you with us.

Mr. KIRK. It is nice to be here.

Mr. JEFFORDS. This is one of only two or three field hearings that we will have. And I can tell you that from the testimony that we have had so far that it certainly verifies why we are here and how important it is to get out into the areas where the programs are working to see how they are working.

And there is no better place to find out than Vermont, especially as far as innovative ideas on how to do more with less which we have always been pretty good at. So go ahead.

STATEMENT OF JERRY KIRK, CHAIRMAN, STATE ADVISORY BOARD, VERMONT OFFICE ON AGING

Mr. KIRK. Thank you. My name is Jerry Kirk, and I am Chairman of the State Advisory Board to the Vermont Office on Aging. I want to thank you, Congressman Jeffords, for the opportunity to come in, and particularly the members of the Human Resources Committee for the opportunity to come in and address not the problems but the reauthorization of the Older Americans Act.

I think essentially that the Older Americans Act does require some modifications. I think that you mentioned earlier something about fine tuning. And I think that is what we need, but we do not need a major overhaul. The aging network that has been in place since 1965 has developed to the point that what is needed more than anything else in 1988 is a strong financial commitment to support the programs at an adequate level.

Now I have some recommendations, and some of them have already been covered, on specific aspects of the Act. And these are based on a desire to augment and improve needed services without imposing unnecessary administrative burdens. I think that the Older Americans Act as such is a fine example of how a federal program can flex to accommodate local and regional needs.

First of all, on this question of cost sharing of mandatory fees replacing the existing system of voluntary donations, I strongly urge that you reject any such change. Some state funded systems may be able to accommodate such a sliding fee scale for in-home services, and these can certainly continue under a voluntary systems.

But imposing a system of mandatory fees on the Older Americans Act services would inevitably result in the loss of participation by many elders in needed services. It is precisely this voluntary and anonymous nature of the participant contributions that allows us to serve a wide variety of elders without a welfare stigma.

Mr. JEFFORDS. Excuse me.

Are you suggesting then sort of a recommended contribution based upon income?

Mr. **Kirk**. No. I am suggesting that we continue with the present system. When you walk into a center, for example, you have an envelope. You walk in and no one knows how much you exactly put in there.

Mr. **Jeffords**. I understand the system, but I was not sure what you meant.

Mr. **Kirk**. But the idea of imposing a sliding fee scale where you say now if you will list how much you make, you see, it makes a welfare stigma out of the system.

Mr. **Jeffords**. I understand.

Mr. **Kirk**. And this is the problem. And that is the reason that I think that we should reject anything that deals with that area.

And second, regarding priority services, such as the legal assistance, I urge the continuation of language that mandates an adequate level of funding as opposed to a specific percentage of federal allocations. Forcing the application of a uniform percentage distribution would remove the important ability to target resources as needed in a given region. The existing system of requiring the State Unit on Aging to ensure that such funding is adequate should be maintained.

Third, the eligibility for Older Americans Act programs should remain at 60 years of age. Now I realize that the older American today is becoming healthier and that they are living longer than they did in 1965 when the Act was passed. But those healthier elderly are precisely the ones that we want to bring into our program in greater numbers, so that they can better enjoy and continue an active and healthy participation in their communities and help others in the process.

Strength comes from diversity. And any attempt to reduce the diversity should be viewed or at least I view it as no more than an attempt to weaken the constituency and eventually lessen the funding.

And fourth, there should be no consolidation of Titles 3B and 3C. States currently have the ability to transfer up to 30 percent of their funds from either of these titles one to the other. And that percentage could be raised. So if you consolidate, the result could be that you would lose the focus on the mandates on the various services that you have under the Act.

Mr. **Jeffords**. Excuse me again, if I could interrupt you. I was responsible for that 30 percent shift back and forth.

Do you think that there could be more, or is that about right?

Mr. **Kirk**. I think that is a good area. What I am concerned about is that if you consolidate 3B and 3C with the mandates that are on each one of them. They now are well spelled out. So the State and the Area Agencies in looking at them, they know in what direction to go, and they have begun to program that way.

Now if you put the two together, you begin to lose some of the focus in an effective Act. And when you lose that focus, then you divert funds sometimes in areas where it is not as appropriate.

Mr. **Jeffords**. Is that 30 percent about right, do you think, or could it be more?

Mr. **Kirk**. Yes, I think that is a good area.

Mr. **Jeffords**. Thank you.

Mr. **Kirk**. And fifth, the language mandating the AAA's advocate on behalf of older persons and comment on public policies affecting elders must be strengthened to clarify that the restrictions of OMB Circular A-122 do not apply to AAA advocacy activities.

And further, that the IRS's restrictions on lobbying by tax exempt organizations should also be identified as not applicable to an AAA's advocacy efforts. Without these clarifications of our advocacy mandate, we are always stopping and looking over our shoulders to see if somebody is not starting down and saying do not do that, you know, that you cannot do this.

Finally, I urge Congress to place the Long-Term Care Ombudsman Program in a separate Title 3D. That is an important program, and it is a program that focuses on the need of the elderly and particularly the frail elderly. And it can serve its important functions without having to compete with already limited funds. It needs better funding.

The residents of America's nursing homes are our frailest citizens, and they deserve the benefit of an Ombudsman Program that is both reliable and adequately funded to accomplish its work.

The Older Americans Act to me is a good Act. It functions effectively. The mandate of the Act is carried out in the Act. It provides the elderly with an array of human services and programs that assist them in maintaining their independence and dignity within their homes and within the community. It is a good Act, and it works effectively.

Now improving the Act is important, and with that I agree, the fine tuning and the modifications. But it is also important to avoid any action that will lessen the effectiveness of the Act.

I would like to thank you for the opportunity to give you my approach at least to the problem.

[The prepared statement of Jerry Kirk follows:]

PREPARED STATEMENT OF JERRY KIRK, CHAIRMAN, STATE ADVISORY BOARD, VERMONT OFFICE OF AGING

3/28/87

My name is Jerry Kirk, and I am chairman of the State Advisory Board to the Vermont Office on Aging. I want to thank the distinguished members of the Subcommittee on Human Resources for this opportunity to speak in regard to the reauthorization of the Older Americans Act.

Essentially, the Older Americans Act requires some modification, "fine tuning" if you will, but not a major overhaul. The aging network that has been put in place since 1965, has developed to the point that what is needed more than anything else in 1988, is a strong financial commitment to support the programs at an adequate level.

I will offer today several recommendations on specific aspects of the Act, and these are all based in an overriding desire to augment and improve needed services without imposing unnecessary administrative burdens. The Older Americans Act is a fine example of how a federal program can flex to accomodate local and regional needs.

First, regarding any suggestion that a cost-sharing system of mandatory fees replace the existing system of voluntary donations, I strongly urge you to reject such a change. Some state-funded systems may be able to accomodate such a sliding fee scale for in-home services, and those can certainly continue under a voluntary system, but imposing a system of mandatory fees on OAA services would inevitably result in the loss of participation by many elders in needed services. It is precisely the voluntary and anonymous nature of participant contributions that allows us to serve a wide variety of elders without a "welfare stigma".

Second, regarding priority services (such as legal assistance), I urge the continuation of language that mandates an "adequate level" of funding, as opposed to a specific percentage of federal allocations. Forcing the application of a uniform percentage distribution would remove the important ability to target resources as needed in a given region. The existing system of requiring the State Unit on Aging to ensure that such funding is adequate should be maintained.

Third, the eligibility for Older Americans Act programs should remain at 60 years of age. It is true that older Americans today are healthier and are living longer than they did in 1965, when the Act was passed. Those healthier elders, however, are precisely who we want to bring into our programs in greater numbers so that they can better enjoy and continue an active, healthy, participation in their communities and help others in the process. Strength comes from such diversity, and any attempt to reduce that diversity must be viewed as no more than an attempt to weaken the constituency and, eventually, lessen funding.

Fourth, there should be no consolidation of titles 3B and 3C. States currently have the ability to transfer up to 30% of funds from either of these titles to the other, and that percentage could be raised, so consolidation's only result would be the further erosion of funding due to a loss of focus.

Fifth, the language mandating that AAA's advocate on behalf of older persons and comment on public policies affecting elders must be strengthened to clarify that the restrictions of OMB circular A-122 do not apply to AAA advocacy activities. Further, the IRS' restrictions on lobbying by tax-exempt organizations should also be identified as not applicable to an AAA's advocacy efforts. Without these clarifications of our advocacy mandate, we must continually look over our shoulders as we strive to fulfill our mandate.

Finally, I urge Congress to place the Long Term Care Ombudsman program in a separate title 3D, to give that important program the focus it needs to serve its important function without having to compete for already limited funds. The residents of America's nursing homes are our frailest citizens, and they deserve the benefit of an ombudsman program that is both reliable and adequately funded to accomplish its work.

The Older Americans Act is a good law, functioning effectively to carry out the mandates of the Act to provide the elderly with an array of human service programs which will assist them in maintaining their independence and dignity within their homes and communities.

Improving the Act is important but more important is avoiding any action that will lessen its effectiveness.

Mr. Jeffords. Thank you for a very excellent job.

Mr. Kildee, I have interrupted enough, so I will turn it over to you first.

Mr. Kildee. Thank you very much, Jim.

You mentioned your opposition to the mandatory fee system for the meals.

Mr. Kirk. Yes.

Mr. Kildee. Could it happen, this occurred to me, that in a given day or in a week or perhaps at the end of a month that some people would not come into the center for their meal, because they would be embarrassed because their finances at that time of the month could be rather slim? Do you see a drop-off in the meal program at a particular time when people would feel embarrassed not to be able to meet that mandatory fee?

Mr. Kirk. Well, I do not think that it is the idea of meeting the mandatory fee. The problem is that the people who come into our centers, these people who are part of the nutrition program and come in, these people are coming in both for a nutritious meal and they are also coming in for the socialization that they need. They need that emotional background.

Some of these people, they never really get together with people until they come into that center. Now you say to them okay, we are going to set some fees. And let us see, if your income is $5000 a year, you should be paying so much.

I am involved in a lot of elderly organizations. And the people say to me, you know, we feel free to go down to a center, because we can go in if we put some money in, nobody says anything to us, and it is a place where we can gather where we can get a good meal.

But if you start putting a sliding scale and saying to them tell me how much money you have and that is how much you will have to pay, they will look on it as a welfare program.

One of the problems that you now face in these centers is the fact that a lot of the people who should be there are not there simply because of that. And the aging network faces constantly the need to publicize their areas and to indicate to the elderly that here is a place that you can go and get a good meal, join together, and stay active in your community and become part of it. But if you push them aside, you are losing many of these people. And that is my concern about it.

Mr. Kildee. Thank you very much.

Mr. Jeffords. Just to follow up on that briefly.

Is that also your argument with respect to raising the age?

Mr. Kirk. Yes.

Mr. Jeffords. I wonder if you would give me your perceptions of this. It would seem to me that the real demands of those who perhaps are just at the age of 60 would normally be considerably less than those who are obviously 80.

Would that be generally true?

Mr. Kirk. Well, you know, I am looking at this matter of increasing the age to 65 in two ways.

Mr. Jeffords. What I am trying to say is that would we really save that much money?

Mr. Kirk. It would not save that much money.

Mr. **Jeffords**. It is the people who at 60 who really need it, and yet the percentage would be much smaller, it would seem to me.

Mr. **Kirk**. That is right.

Mr. **Jeffords**. And you would lose that kind of mix you have got.

Mr. **Kirk**. And you need that mix. You need the young old who are coming in. You need some of these at 60 years of age coming in to join with somebody who is 75 or 85. They are needed members.

Mr. **Jeffords**. So what you might gain by the small additional monies available would be offset by the lack of that mix and their helpfulness to others who are older?

Mr. **Kirk**. That is very true.

Mr. **Kildee**. On that point, my observation is that very often the young old are very often the ones who could provide the transportation to that center for some of the older ones.

Mr. **Kirk**. That is right. That frequently happens that way. You will see the people coming into the center and someone is driving and bringing in other people from their area.

Mr. **Kildee**. My mother is 87 years old, and she has a young friend who drives her around. Her young friend is 75. And that is a good mix, too. Thank you very much for your testimony.

Mr. **Jeffords**. Thank you.

Our next witness is Dr. Eloise Rathbone-McCuan. And again our next panel will be Jean Dedam, Mara Coven, and Craig Hammond. And the final panel if you would like to come to the front will be Cynthia Parsons, Faire Edwards, and Wayland Bowen.

Incidently, afterwards Mr. Kildee may have to leave, but I will be happy to stay and listen to others who may desire to testify at the end. Please go right ahead.

STATEMENT OF ELOISE RATHBONE-McCUAN, DIRECTOR, SOCIAL WORKERS PROGRAM, UNIVERSITY OF VERMONT

Ms. **Rathbone-McCuan**. I appreciate the invitation to be invited to give testimony today. This is the first time that I have represented the State of Vermont in formal testimony, because I am not a Vermonter and have not been in the state all that long by Vermont comparisons.

I share the concern with everybody gathered here today about the many issues facing the reauthorization of the Older Americans Act. It is obvious to everyone here that it is the major age based federal social service legislation that we have in this country today, and it impacts upon virtually every social need of the aging population either directly or indirectly.

During the past six years, it is my professional opinion and my political view as a citizen that there have been numerous attempts to retrench the scope of this Act either through narrowing the policy and program interpretations of the various titles and the suggestion of dramatic funding decreases.

Only through consistent vigil of very supportive federal legislators, national organizations, senior advocacy groups and other professionals and citizens have we been able to prevent what I would consider a catastrophic erosion.

As a gerontologist and a social work educator, I feel that I could give you two views today. One is that of an academic. But I am going to leave that aside, because I am certain that you have heard as you have traversed the country a lot of the ivory tower perspectives.

What I am going to talk to you today about is my four year experience of being a board member of the Champlain Valley Area Agency on Aging. It is located in Winuski, Vermont, and it serves the only metropolitan area that we have in the state which is Burlington and the surrounding terrain, and other rural counties that are adjacent to that metropolitan area.

It has been a very interesting opportunity for me to spend four years in a sustained state of contingency planning. As a member of the planning subcommittee of that board, I have spent approximately one hundred hours in consultation with the staff in formal meetings attempting to figure out how we can stretch our dollars ever further in order to be able to serve not only more people quantitatively, but in addition people who are more severely impaired.

Now this has been somewhat disheartening. We have been successful, and we have been quite successful thanks to a good board and an excellent staff. But this has created for many of us a sense of true frustration. Because we have been unable to look ahead towards the future and the changing needs of the population not only within our multi-county area but within the state as a whole.

Now I am going to address my specific comments to four general recommendations. And I want to say that I am going to be interfacing between the issue of legislation and policy interpretation. Because I think that it is true that we can continue to revise, and add and reframe new titles to each of the acts in the overall legislation. But it is the policy interpretation and it is the policy guideline which gives the flow and substance to the programmatic delivery of this act at both the national, state and local level.

First of all, I would like to urge you about the importance to create greater flexibility for developing service delivery models that are applicable for non-urban areas. My point is simply not to say that the older rural Americans are getting short changed as compared to urban older Americans, but my concern is with the increasing degree of policy interpretation rigidity that is emerging in my view from a very urban bias that exists in Washington and that is often filtered down with direct service impact not only to rural states, but also to those rural regions within urban states. And I would point to such states as Michigan and Illinois which is my home state.

And I would suggest to you that in order to meet some of the issues, the service delivery issues, that we have been hearing about all morning that it becomes essential for rural states to be able to have the flexibility to take the mandated goal of legislation and the mandated policy thrusts, and to be able to innovate within the economic and environmental constraints of a rural state and a rural region, which is quite different than an urban or suburban environment.

My second recommendation is the need to consider expanding the scope of the Older Americans Act to include a social service response with an inter-generational orientation. I would like to say very clearly that I am not one of those who is on the current bandwagon of the inter-generational equity theme.

But what I would like to suggest to you is that I see basically the Older Americans Act, because of the demographic aging of the population and the multiple cohorts that are within the age 60 and older, that what we may be seeing is in fact for those who are agewise entitled to Older Americans Act services that we are dealing with an inter-generational aging population.

To give you but one example. Increasingly when we hear about the issues of the young old and those things that are becoming the most pressing anticipated reality to their own aging is not so much their anticipated health decline or necessary economic security breakdown for themselves, but for the aged parents who at age 60 that they are responsible for taking care who are living to age 85 and age 90.

And for them as they are entering into the era of their young old period and their hopefully enjoyable retirement phase of life that what they are confronted with is a burden not only potentially of their own aging but their aging inter-digitated to the continual existence of very, very frail parents and other relatives for whom they may be the only living family member.

So I would like to urge, and I am going to use a label because I do not have another word for it, that we think about the possibility of either reexamining the current title and the current policies of the Older Americans Act or perhaps introducing a new title called the Aging American Family title.

And this title would basically be geared to try to provide the possibility that we see that the aging process is an inter-generational phenomena, that we do recognize that many of the issues that the Older Americans Act attends to through the provision of either advocacy or funded services are services and social problems that have a family impact.

Another thing that I would like to suggest is the importance of there being a reconsideration of the whole issue of targeting. I think that it is exceedingly difficult for policy and the whole decision making process to consistently argue for the policy of targeting when what we are really doing is struggling to find oftentimes ever fewer resources to be divided among other ever greater numbers of at risk groups.

I find it very difficult to justify either from my own professional experience, or from the data or from any possible source that it is more important to target on the needs of the minority elderly in inner cities than it is to target on the needs of the rural, very poor and very isolated aged such as we have been hearing about today.

And I would simply urge that we need to rethink the issue of targeting, so that we are sure that it is not a policy process which is creating greater social injustice than it is intended for the cost savings around which it was designed.

And the last thing that I would like to address would be to review briefly the mental health service gap that I see for the rural aged, and the whole question of how the Older Americans Act legislation certainly not in isolation of other federal legislation but in active partnership may address this.

Allow me to quote for one brief second from the recent Vermont State Department of Mental Health five year plan entitled Mental Health Directors for the Future. And this is the document which guides the whole prioritization and implementation for public mental health services in our state.

To quote:

> Only 2.2 percent of Vermont's mental health budget supports services for people 60 years and older with long-term mental health needs. The fourth critical area in the Vermont mental health five year plan was the development of mental health services for the aged.

Now they say "was". Because as the State Department of Mental Health looks at its current resources, it finds itself totally lacking in an ability to make any kind of meaningful priority for the other kinds of issues such as care of the institutionalized younger chronic population and the aged.

Only a few of the ten community mental health centers within the state, and that would probably be on the average of two per Area Agency on Aging service planning unit, have staff with an interest in or knowledge about gerontological mental health. And only six FTE staff, and that is the full-time equivalent at whatever level of training they may be, are assigned to services to those specifically age 60 and over.

My Area Agency on Aging has been trying for four years to try to find some what we call non-AOA money, different kinds of small foundations or competitive monies that the state has made to the Vermont Independence Fund, in order to be able to get some money to do even a modest degree of program development in the area of mental health.

Because what we are seeing in our region is a very kind of frustrating and cyclical thing. The community mental health center that serves our area is one of those centers which basically has on staff no expertise in the area of geriatric mental health.

When they receive a referral about an isolated elderly person living in Burlington, their immediate inclination is to basically call the Area Office on Agency. Because if that person is 60 years or older without having geriatric specialists, they turn to the system which is designated to deal with that individual by the definition of chronological age.

So oftentimes what we see as the situation is the Area Offices on Aging because they have no mental health service capacity are basically dealing with very chronic and sometimes acute episodic situations where the advocate goes out and the advocate is faced with, to quote someone else here, "exceedingly complex situations" of individual management.

I will not even bother to go into the implications of this recommendation for the increasing press that is occurring for trying to take care of early stage and middle stage Alzheimer's patients in this state.

I would simply say to you that in my judgment that one of the most neglected areas in the Older Americans Act and nationally for rural Americans has been that issue of mental health. And I would suggest to you that the problems are not going to be decreasing, but they will be only increasing as our population trend lines play themselves out. Thank you.

[The prepared statement of Lee Rathbone-McCuan follows:]

PREPARED STATEMENT OF ELOISE RATHBONE-MCCUAN, SOCIAL WORK PROGRAM, UNIVERSITY OF VERMONT

March 26, 1987

Testimony delivered to members of the U.S. House of Representatives, Committee on Education and Labor Subcommittee on Human Resources at a hearing for the reauthorization of the Older Americans at held March 28, 1987, in Montpelier, Vermont, presented by Eloise Rathbone-McCuan, Coordinator of Social Work Program, University of Vermont.

I appreciate the invitation to make this presentation. I share with everyone gathered at this hearing, a concern about the future reauthorization and content of the Older Americans Act. It is the major age-based federal social service legislation and impacts on the social needs of all senior citizens. During the past six years, there have been numerous attempts to retrench the scope of the Act, either through narrowing the policy and programmatic interpretations of various titles or drastic funding decreases. Only through the consistent vigilance of national political leaders, professional organizations, advocacy groups, senior citizens and professionals has major erosion of this comprehensiveness legislation been prevented.

As a gerontologist, a social work and professional educator who studies and writes about social needs of the elderly, I could offer an "academic" perspective on these issues. However, many of my scholarly colleagues, nationwide, have already contributed their empirical and theoretical views in support of the Older Americans Act. Today, I speak from the position of a Vermont resident serving on the Board of Directors for the Champlain Valley Area Agency on Aging, (CVAAA). CVAAA serves Chittenden County, Vermont's only metropolitan center, and the surrounding rural counties. Because the Older Americans Act provides the major source of our agency's funding and the amount of state contributed dollars for programs is very limited, I know the serious impact of "contingency planning" and "planned service reduction strategies" at the local level.

For four years our AAA has faced the harsh realities of having to prepare to offer more services to be delivered with less funding due to anticipated and actual budget problems. We have managed to accomplish that goal because of quality administrative leadership and very tight fiscal management policies. But other agencies haven't been that successful and have encountered sequential reductions in service provision capacity. Some senior citizens in Vermont have found no stable service replacement source when and if OAA funded programs are reduced or eliminated.

As a volunteer, it has been frustrating for me to serve on the CVAAA Program Planning Committee and never once in four years have the opportunity to dialogue with staff about designing new programs. They agency's staff is a committed group who never manifests defeat from the constant pressure to protect the core service delivery capacity. Our agency, like others throughout the country, would like to move ahead to address neglected concerns. It is my position that the future of the Older American's Act must be financially stable and that new legislation and policy directions need to emerge quickly in order to meet immediate and emerging aging population service needs. In my remaining comments, I will respond to those future issues I predict to have major impact on the elderly in nonmetropolitan areas.

- Create greater flexibility for developing service delivery models applicable for nonurban areas

My point is not to argue that rural older Americans are being discriminated against in favor of their urban counterpart. My concern is that with increasingly rigid program policy interpretations, most frequently made by bureaucrats with limited understanding or interest in rural America, service planners in rural areas are being forced to adopt urban-based service delivery configurations that may not be most appropriate for the aging rural population. Future OAA policy directives must provide for flexible innovation and program model adaptations for rural states and rural areas in urban states. The principle of "program flexibility" is necessary for AAAs serving rural elderly. The overall impact of increased federal appropriates for OAA funded services is going to have less benefit for rural elderly unless rural state and local program units are assured, through clear federal policy directives, that they have the needed flexibility to demonstrate service innovations according to the social, economic, demographic and geographic realities of our their areas.

- Expand the scope of OAA sponsored social service programs to include intergenerational supports.

It is documented repeatedly that rural aged depend heavily on help from family members and younger people in their social network. As rural residents they face different environmental circumstances that influence their reliance on others to provide help. It would be very enlightening for us to hear first-hand what is faced by younger rural residents providing informal community care to elders. For example, a middle-aged divorced daughter, with a full-time job in St. Johnsbury, picks up her elderly, almost blind father in

Swanton, and transports him each month to the vision clinic at the University of Vermont Medical Center. Her small business employer has no provision in his personnel benefit policies to give her 12 day off for this particular elder care responsibility. She doesn't have the option of taking a "personal leave" day once a month. Relying on an agency-based source of transportation may get her father to the clinic door, but this arrangement leaves him alone at the clinic to cope with a strange environment; stressful medical procedures and this daughter would be without the benefit of first-hand knowledge about her father's vision. The time and undependability of transportation in rural areas and the time and distance involved to reach major professional service centers makes such supportive actions very difficult.

I recommend, with all possible priority, the need to examine the future capacity of the Older Americans Act to provide diverse forms of intergenerational caregiver assistance. I would like to see a survey conducted using rural AAA employed advocates as the sample of information providers. Much of their advocacy activities with rural elderly has direct intergenerational care giving implications, however their service mandate does not allow for the provision of much, if any, support to caregiving family members. These advocates are knowledgeable through their daily contacts about the need for an intergenerational advocacy and direct supportive service approach.

The Older Americans Act needs to be expanded to create a national service deliver program capacity for what I'll label the "Aging American Family Amendment". My assumption is that the emerging cohorts of rural "young-old" are going to have ever less need of the current model of social/recreational services readily available and more need of services that help them cope with the care demands from their very aged relatives. After all, by virtue of the elder care-giver reaching age 60, they should benefit from Older Americans Act funds being directed toward their most immediate social needs. Respite programs are but one example off an intergenerational service benefit.

- Allow for greater flexibility in the state and local level interpretation of "targeting" and "service" prioritization.

Allow me to again return to my local Vermont AAA planning experiences. Very recently, our senior staff and the planning committee reviewed new data on congregant and home delivered meals within the multi county service area. Since the period of full implementation of DRG policies in our local hospitals, we have experienced a definite increase in the demand for home-delivered meals and a comparable decline in the use of congregant meals. This may be the beginning of a national trend toward greater inhome delivery capacity. One interpretation we have discussed is rather alarming: our long standing senior citizen constituency who has participated historically in the range of congregant services may be becoming too frail and immobile to effectively utilize out-of-home programs. My question as a board member is, "What are the implications if CVAAA is to become increasingly more involved with in-home/home based services to the permanently frail and fast failing elder population?". There is much national discussion about the necessity of prioritizing OAA services to those at greatest-risk, but have we assessed adequately the policy implications of having Older Americans Act services transformed into the universal geriatric social service system that supports the community-based long term care enterprise. I think not and suggest this possibility must be considered by social policy experts.

- Review the mental health service gap for the rural aged and assess the future role of OAA legislation.

The following quote from the Vermont State Department of Mental Health Five Year Plan entitled Mental Health Directions for the Future, indicates clearly why there is a serious gap in mental health service provision to the rural elderly in this state:

> Only 2.2 percent of Vermont's mental health budget supports services for people 60 years and older with long-term mental health needs...The fourth critical area of need in the [Vermont] Mental Health Five Year Services Plan was the development of mental health services for the elderly. Only a few of the ten CMHCS have staff with an interest in or knowledge about gerontological mental health and only six FTE staff in the state are assigned to services specifically over 60 [years of age].

Several times the CVAAA has pursued small independent grant sources in order to expand mental health services to provide evaluation backup and referral resources to other local agencies. Money through OAA sources has never been available to provide even a small mental health program affiliated with the AAA network. When our local community mental health resources, public and private, encounter an elderly person with some acute or episodic emotional problem, mental health workers call the area agency on aging for assistance with the aged person. The AAA is not equipped to offer much assistance to those elders manifesting incapacitating psychotic symptoms, coping with protracted deep depression or floundering alone with early phases of cognitive deterioration associated with Alzheimer's Disease.

In Vermont, the present climate for cooperative efforts between the state mental health system and aging service network is good. That cooperative orientation also seems present at the local level. Unfortunately, the positive attitudes toward program collaboration remains unactivated largely because there are no extra funds for program development in either system.

National attention has turned to community-based care for the younger chronic mentally ill population. Most of the very aged population originally deinstitutionalized in the first waves of discharge have died quietly in nursing homes and community care facilities. Even so, chronic mental illness, affecting some 1.7 to 2.4 million people, is accompanied by complexities of the aging process. The community mental health system is just beginning to see the interactive impacts of the aging process on the new cohorts of chronic mentally ill reaching the young geriatric stage. The apparent response of the mental health system to this emerging patient group is to turn to the aging network since those people are becoming chronologically old. A very large majority of local AAAs, especially those in rural areas, are not able to respond with an appropriate services. In my professional judgement the mental health service delivery capacity to rural elderly at a crisis point. Lack of mental health policy initiative within the Older Americans Act that are coordinated with the National Institute of Mental Health is a most serious omission. Thank you.

Mr. **Jeffords**. Thank you for a very well reasoned and well articulated statement.

One of the areas that you mentioned was the inter-generational aging situation. We do have a bill before our committee, not necessarily the subcommittee, that is called parental leave, and it does allow also for children regardless if they are close to the aging to have the right to take time off for helping.

What are your feelings on that?

Ms. **Rathbone-McCuan**. Well, I am a very strong proponent of a whole range of respite possibilities. And I think that if we really do want to protect the quality of life of the American family that we are going to have to take very seriously a range of areas on respite care of all forms.

Mr. **Jeffords**. You mentioned that you thought that there ought to be a title in this general area.

Could you give us an idea of what the structure of that title would be and what its main goals would be?

Ms. **Rathbone-McCuan**. Well, basically, I think to give you one example, it would be to assure that the Older Americans Act and the service network that it funds has a greater ability to be able to say for instance advocate for multiple needs within a family.

For instance, let us use the aging care giver. I think that often that individual has, even though they may not be the designated client, often has a great deal of need in order to be able to figure out how they can get the public benefits that are needed by their aged parent.

So when we are talking about advocacy, I think that in some ways we are talking about advocacy on behalf of the care giver to be able to carry out the care, the financial and social responsibilities that they feel toward the elderly person.

I think that another aspect of this legislation would be to have inter-generational respite and care giving assistance a major part of this Act. Now it is fine to have it in other legislation. But if it does not come directly into the mainstream of the Older Americans Act upon which the entire system is built, how can that system be expected to respond to it if it is a parallel piece of legislation instead of built into the core.

Mr. **Jeffords**. Thank you very much. Mr. Kildee.

Mr. **Kildee**. Thank you, Jim.

The respite aspect that you just mentioned is very interesting. I mentioned earlier that my mother is 87 years old, and my sister is 65. While I get home every other weekend back to Michigan, my sister has a lot of the responsibility. Very often, it does fall to the daughter for a variety of reasons.

But you can see a need for some respite there too for that younger generation, the young old, who very often are involved in this growing phenomenon of two generations that are really qualified for these programs now, and it is a growing thing.

You made an interesting observation, too. You mentioned an urban bias in Washington. And of course, my initial reaction is to bristle over that. But, you know, you raise an excellent point, and I am not bristling.

Ms. **Rathbone-McCuan**. Good.

Mr. KILDEE. Because I think that it can be there, particularly in the House of Representatives. With the exceptions of states like Vermont, or South Dakota or North Dakota, by the very nature of their representation, there can be an urban bias particularly in the House. Not say in Vermont, South Dakota or North Dakota, because Jim Jeffords here is like a third Senator in a sense because he represents the entire state down there.

But you do find that. That decision made in Philadelphia two hundred years ago, the result of that is that urban areas, of course, are well represented in the House, and the rural areas are better represented in the Senate.

And I think that what we have to do is remind ourselves of that as we pass legislation in the House, that that bias does exist. Because you do not have many situations like Jim Jeffords'. We do not have many states really where the Congressman is really like a third Senator. That is the exceptional thing there in Washington.

So I appreciate it. I knew this, but very often there is a difference between knowledge and realization. Very often, someone helps you make it real in your life. So I think that is something that we have to watch constantly.

You mentioned the respite and the mental health problems. It is something that we have to wrestle with because we try to put as much as we can into the Older Americans Act to cover the various needs of the older Americans.

We have to ask ourselves the question, what might be more properly in the Older Americans Act, and what might be more properly in say Medicare, or what programs may have to run parallel in both.

I guess that one of the things that we are concerned about is that, as we do emphasize more of the health care aspects in the Older Americans Act without increasing the amount of dollars, then what are we pulling away from other programs? I think that maybe we have to try to run the two in parallel, Medicare and the Older Americans.

Ms. RATHBONE-MCCUAN. May I respond to that for just a minute?

Mr. KILDEE. Yes, please.

Ms. RATHBONE-MCCUAN. Because in my earlier opening remarks, I made the issue of maybe it is not just always a matter of a new title that says that the Older Americans Act shall provide mental health.

What I am increasingly concerned about is the extent to which all of the other aspects of human and health legislation, national legislation, should be providing some kind of a cooperative integrated policy orientation whereby these other systems such as the public mental health system in this country are in a position to be able to carry out their responsibilities to the elderly population.

And so what I would urge is not that we necessarily put it—we cannot put everything in the Older Americans Act, that is true. But we certainly can, if we believe that that Act is really even a national and in Washington a watchdog advocacy, we can give it more strength to be able to be a mandated major source of input with other human services policies that impact on mental health and social welfare.

Mr. **Kildee**. Doctor, I really appreciate very much your testimony this morning. I hope that the subcommittee can stay in contact with you, so we can be the beneficiary of your ideas.

Ms. **Rathbone-McCuan**. Certainly.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. Thank you.

Our next panel is Jean Dedam, the Director of the Northeast Area Agency on Aging; and Craig Hammond, the Director of the Central Vermont Area Agency on Aging; and Mara Coven, the Director of the Champlain Valley Area Agency on Aging. we are pleased to have you with us. Whoever is ready to go can go ahead.

STATEMENT OF CRAIG HAMMOND, DIRECTOR, CENTRAL VERMONT COUNCIL ON AGING

Mr. **Hammond**. I am Craig Hammond, and I direct the Central Vermont Council on Aging, one of Vermont's five Area Agencies on Aging. This is Jean Dedam who directs the Northeast Area Agency on Aging.

First of all, I want to thank you for coming to rural Vermont, or to Vermont which is rural, or to say thank you for coming to rural America. Sometimes we do not feel well represented or listened to, as has just been spoken to by Lee, and we appreciate this opportunity.

As an Area Agency director, I want to speak to the Act and its reauthorization from the standpoint of community based services which I believe to be at the heart of the Act's intent as well as its growing impact over the past fifteen year.

Our job has been to plan and provide for and including the funding of such services which support continued independence and well-being among our older citizens.

Client advocacy is the critical philosophy and dynamic of Vermont's Area Agencies on Aging. As such, this dynamic not only underlies each and every instance where older clients' rights and entitlements are represented, but also each and every meal, every and ever home visit, and each and every ride to the doctor.

It is out of this advocacy perspective that many of find certain features proposed in the reauthorization to be commendable and to be supported, and others not to be.

With regard to cost sharing in general, I believe that Area Agency directors in Vermont oppose it. As all other Area Agencies across the nation, we have also experienced the tremendous pressures on us to increase non-federal revenues to support continued strong levels of client service.

The temptation to charge a fee is with us and the "ability to pay" basis. Yet it is a poor solution. It threatens to turn the nutrition program into a caste system. Certain wealthier communities will have little trouble reaching their cost sharing levels, and they could in the process become membership or club-like enclaves which discourage or prohibit participation of lower income neighbors.

On the other hand, areas or neighborhoods with a low income concentrated population could very well end up having their cost sharing subsidized and thereby run the risk of becoming stigmatized welfare feeding programs for the poor elderly.

Currently, we promote and I must say quite successfully open participation across the income spectrum on a suggested donation basis of between $1.25 and $1.50 per meal. Initiated last spring, we have witnessed our average congregate meal participant donation increase from around 75 cents to over a dollar at most sites, and at some meal sites to over $1.25. In our nutrition services, we are clearly and substantially supported by participants.

In the area of Title 3B, supportive services, we have taken the position that the same policy should continue to apply here as for nutrition services all the while cognizant of the Act's silence about other than nutrition services being subject to voluntary contributions.

All Area Agencies raise substantial donations for transportation services provided. In the past year, at least three of the five Area Agencies have instituted donation procedures for client service coordination services.

Other services would be exempt from mandatory cost sharing under the reauthorization wording, but there is no mention of care or case management per se in this section of the Act. There should be some mention or identification of where exactly that might fit.

What remains for cost sharing, in other words, are in home services, respite homemaker, friendly visiting, reassurance and a variety of housing support services. In Vermont, many of these programs draw funding support in part from the Older Americans Act Title III, since their base grant funds, Action, Title V, state general funds and so on and so forth are almost always insufficient to adequately or to entirely support them.

I suggest that in moving from what I might call open enrollment to means tested entitlement that we would lose people, that many of those in greatest need will select themselves out of the system, and that over the long run that even fewer older persons in need will be served. And it is exactly for those very people for whom these in home programs are intended to serve.

Number two, the authorization and appropriations discrepancy. We neither seek to protect the older clients from the opportunity to cost share on a donation rather than fee basis, nor do we believe that there is an inexhaustible source of non-federal community, corporate, business, United Way, or city or town fund support to show up or to expand these critical services.

And I might say that in many areas of Vermont that there is no such thing as corporate. And in other areas of Vermont, there is no such thing as United Way.

To adequately and efficiently fund a continuum of community based services which empowers independence among older Americans, it requires nothing less than placing our funds where our social policy is. To do less threatens greatly to reduce the effectiveness of the Act.

The State of Vermont has increased its share of support many fold in the areas of adult day care, client service coordination and housing support in the past few years. This year may very well be the year when the state agrees to an increase in the personal needs allowance for nursing home residents from $25 to $45.

For states such as ours without revenues of energy producing of highly productive industrial states cannot adequately cost share with the federal government in support of Older Americans Act services. We are forced to raise more and more within our own service areas, and at the same time must request more federal support.

I think that I have my numbers right here, but I am not sure. Someone correct me if I am wrong, but it seems like a lot of money that I am going to speak of.

In 1987, the authorization levels within Title III are a full $160 million greater than the amount actually appropriated. Yet it is the authorization level which Congress sets to enable Area Agencies the ability to meet identified critical service needs.

For several years, this problem has occurred. We do not make up the shortfall. Services remain under-staffed, and staff remain under-paid. And on an average most service staff work well beyond their compensated time, because they care so much for the elders that they serve.

We appreciate what efforts are made to protect and even enhance our funding. We, of course, would appreciate it even more that our actual appropriations would truly approach authorization levels.

Currently in Vermont there is an identified need of over 4000 elder individuals who have required client service coordination services. These are in addition to the 10,000 already served.

On another matter, Vermont's Area Agencies do not exceed their 8.5 percent allowable administrative limit currently, nor have they in recent years. If pressures to maintain such low administrative costs mounts unrealistically, particularly in light of the increasing number of small service grants that we take on with little or no allowable administrative dollars whatsoever, I for one support limits but request stricter limits on the piggy-backing imposed by other resource funded programs of the core administration allowed us under the Older Americans Act.

Number three, case management. In general, I find support for inclusion of case management into the Older Americans Act. Our national organization does support this effort, and is developing an approach under the term care management to build for consistent case management services.

Our concerns, however, lay more with how such inclusion in the Act will affect our ability to advocate on behalf of older persons. Direct service provision by state labor is very much a part of Vermont's five Area Agencies.

So while we are very much in the process of sorting out exactly how to further develop case management and what implications that will have for the future of direct services, it is becoming more and more clear that we may not be able to continue to provide both direct services and case management services.

I believe that we can at least recommend that extreme discretion and care be exercised in how case management becomes incorporated into the Act. If flexible rather than prescriptive language is used, then Area Agencies nationwide can continue to build systems appropriate for identified needs.

We in Vermont seem to be developing a client directed team consortium approach to case management under the name of client service coordination, which requires participation up front by the older client, by home health, hospital discharge, mental health and Area Agency personnel where the client requests and requires the services of two or more agencies to meet several related needs.

I must say parenthetically in reference to the last testimony that it is often difficult to find that mental health person though, because they really are not funded to work with older people.

In other to refine this approach, we need more time without national case management standards. Yet in time such standards will become very appropriate and helpful.

We also need money. It comes very difficult to do more each year with less. This is particularly difficult with the Older Americans Act which expands the scope of our work without appropriation.

Number four, transfer of funds. I for one and I believe that most of my colleagues and their Area Agencies oppose the consolidations of Titles III-B and C. To do this would be in essence to bloc grant funds for community based services, and thereby give over authority to states for how these funds would be used.

Such authority does not protect established and proven services. In fact, it makes nutrition services particularly vulnerable at a time when their impact is critical and when there are insufficient local resources in many communities to absorb what could amount to be a large transfer of funds from nutrition into client advocacy and in home services.

Also in Vermont, it is my understanding, that we currently do not even transfer the allowable 30 percent. So it seems highly inappropriate at this time to support legislation which would further expand this transfer of authority.

With regard to the Ombudsman Program in a separate title status under a Title III-D, we support that, and I defer to Patrick, and Catherine and Jim who spoke earlier.

With regard to commodities, there is also a suggestion that the commodities reimbursement rate be increased, and we support that. We should never had the rate reduced in the first place a year ago, and still will not have regained lost but necessary funds even with the rate returned to its present level. Costs of food personnel, consumable supplies and delivery all increase annually, and recognition of this effort would be most helpful.

Also as was spoken of in the panel discussion by the nutrition program personnel, the commodities program combined with donations enables more and more local communities to support congregate meals programs without Title III-C subsidies. Therefore, the stronger the commodities program, the stronger its per meal reimbursement, and greater can be the incentive for local communities to sponsor and even start up new congregate services.

With regard to advocacy in the Act and what has been mentioned several times so far, the OMB Circular A-122, we appreciate the language in Section 306 which further protects Area Agencies for prohibitions of Circular A-122, and which as a consequence frees us up to better fulfill our public issues advocacy mandate.

However, as has also been spoken of, we believe that a far more critical a barrier to effective advocacy of this nature is the IRS 20 percent restriction on the use of non-federal funds by private nonprofits for lobbying and other issues of advocacy. These activities are specifically restricted under the Tax Reform Act of 1976.

Mr. **JEFFORDS**. Thank you very much, Craig. Jean.

STATEMENT OF JEAN DEDAM, DIRECTOR, NORTHEAST AREA AGENCY ON AGING

Ms. **DEDAM**. Good morning. And thank you also for coming here and listening to our concerns.

I want to focus on advocacy, case management and the funding. I feel that advocacy as mandated by the Act is a very appropriate activity, and I would like to speak to the individual advocacy per se.

In this rural state, we provide individual advocacy to seniors in their homes, or at meal sites and senior centers. Because of the rural nature of the state and transportation problems of many elders, the home visits are important.

The services provided by advocates who work primarily with the frailest and the economically neediest elders, advocates have a comprehensive knowledge of the regulations of federal or state benefit programs, alternative housing programs and a multitude of other support services including transportation, meals, health and in home care, legal services, chore services, telephone reassurance, senior companions, and long-term care options.

Advocates have an approximate average case load of around 175 clients. Our advocate system is based on the principle of self-determination. The advocates do a complete assessment of each client situation, describes all of the options available to the client, and then assist the client where appropriate to maintain maximum independence if the client wishes. Advocates have many cases where clients have a variety of support needs and providing case management services, or something that approximates it.

Because our agency provides very few direct services, our advocates are in a position where conflict of interest is not a major problem. Advocates are trained to look at the whole situation, health, financial and activities of daily living needs.

And the reason that I mention that is because I think that most other resources for case management would have a more focused interest in the management of services for an elderly person, either health or maybe social. But they are not trained to look at the overall needs of the client in the way that an advocate is, and have the same kind of comprehensive background in the services available.

There is currently a lot of discussion on case management, on fees for service and on donations for support services. Up to this time, advocates have been able to provide advice and services without completing an eligibility determination for services from an advocate, or asking for donations.

Advocates are in a sensitive position with their clients, because they acquire fairly complete information on client income, resources and expenses which puts them in a compromising situation when asking for donations.

Because our services are targeted to the neediest members of our client population, it seems inappropriate to ask for donations for every service provided to each client, especially when the neediest are receiving the most services.

If we ask them for donations for transportation, for meals, for advocacy and for legal services, it becomes a difficult situation. We are here to offer help, and then at the same time we are asking for money for everything that we do. It is not a comfortable situation to be in, and I do not feel that it is an appropriate situation for us to be in.

Along the same line, it could be argued that the need for services is expanding to those seniors who are in less immediate financial needs. But because of the potential catastrophic costs related to health and/or long-term care, they may need advice and guidance with insurance problems or financial or estate planning.

That is not to say that we would be doing financial or estate planning. But there are so many issues that need to be considered, and a person may need some advice as to where to do and where to start, do you call your lawyer or do you call your financial planner. And I am not talking about people with extensive resources, but they have resources that takes them beyond the poverty guidelines, but could be used up very quickly if they were not aware of how to plan for long-term care needs or health, as to what could happen with the health costs.

Do we charge for these services, or refuse to offer information to these clients. I think that we should not be charging for these services. I do not think that fee for services is appropriate for the Area Agencies. What I am saying is that I would like to support what Craig is saying in terms of the appropriations.

We are mandated to do certain things for seniors, and we are in a position to offer these services better than other agencies who provide these services. And we need the appropriations in order to fulfill that function.

The local support issue. We do receive a lot of local support, especially in terms of the nutrition program. And that is appreciated, and it is appropriate. However, to ask for more local support, to ask for donations, to do eligibility determinations seems inappropriate. And I am supporting the fact that we need the appropriations in order to do what we have been asked to do and are in the best position to do.

Mr. JEFFORDS. Thank you very much. That was another excellent statement. I would like to put into the record now also the statement of John Campbell, the Executive Director of the Southwestern Vermont Area Agency on Aging. I would put that into the record, if there is no objection.

[The prepared statement of John G. Campbell follows:]

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March 25, 1987

U.S. Congressman James M. Jeffords
P.O. Box 676
138 Main Street
Montpelier, Vermont 05602

Dear Congressman Jeffords,

I am sorry that I will be unable to attend and testify in person at Older Americans Act reauthorization hearing in Montpelier on March 28.

I have included written comments about a specific section of the Act dealing with influencing legislation. My colleagues here in Vermont share my apprehension that, particularly in a rural state such as ours, our ability to communicate information and concerns with elected officials at every level could be severely restricted unless the Act itself includes some clarification about the Area Agency on Aging role as advocates for older people.

In return for your support, and we hope that of your colleagues, we will make every effort to provide you the best local constituent information and impact analysis of proposals that would affect Vermont elders.

I thank you and Representative Kildee for providing us, here in Vermont, with an opportunity to comment on this important national reauthorization.

Yours truly,

John G. Campbell
Executive Director

CC:Joel Cook
James Matteau
Craig Hammond
Mara Coven
Jean Dedam

JGC:ft

A Program Sponsored by Southwestern Vermont Council on Aging, Inc.

Testimony of John Campbell, Executive Director
Southwestern Vermont Area Agency on Aging

Relative to Reauthorization of Older Americans Act
(Specifically, exemption from OMB A-122 prohibition
against using federal funds to influence legislation)

When it was created in 1965, the Administration on Aging, through its Commissioner on Aging, was charged with being an effective and visible "advocate" for the elderly (Sec. 202a). Through the intervening years, the placement of the chief advocate spokesperson and the names of federal agencies within the structure that used to be the Department of Health, Education and Welfare, have changed, but the role to be the "advocate for the elderly" has not.

In the organization sections of the Act, where the powers and duties of the State Units on Aging were described, the implementation of this function was addressed specifically in the following terms: (Sec. 305(a)(1)D) the State Agency was to be the sole Agency to ---

> D Serve as an effective and visible advocate for the elderly by reviewing and commenting upon all State Plans, budgets and policies which affect the elderly and provide technical assistance to any agency ---- or individual representing the needs of the elderly.

Language proposed by our National Association of Area Agencies on Aging would clarify the intent of this section to include federal plans, budgets and policies as well.

Area Agencies on Aging are established by State Units on Aging to implement this advocacy role at the regional and subregional levels. These agencies may be governmental units or, more likely, public or private non-profit agencies. Of the 670 Area Agencies on Aging nationwide, the majority are private non-profit corporations. Many of the publicly-sponsored AAAs have, in turn, spun off local non-profit agencies to further the purposes of the Act at the regional level.

The budgets of many regional agencies across the country are comparatively small. At the last analysis done by the National Association, over 100 AAAs had total budgets under $1 million. The Southwestern Vermont Area Agency which covers 41 towns in two rural counties in the Green Mountain region has a budget of $1.2 million and a staff of 65, including part-time meals on wheels drivers. Our service area is over 1500 square miles. We are very proud of our services, including social work provided by Senior Advocates, Long-term care Ombudsman service and our Nutrition Program. Two-thirds of our budget comes from Title III of the Older Americans Act and other federal sources. We are heavily dependent upon federal funds.

We are very proud in our region, as are the other four Area Agencies in Vermont, to be effective advocates for the elderly. Each Area Agency hosted Medicare Speakouts at the regional level this winter. The information from these Speakouts has been shared with Congressman Jeffords, our two U.S. Senators and members of the Vermont legislature.

One of the virtues of living in a small rural state, such as Vermont, is the ease with which we and our elder constituents can communicate with our lawmakers. They are known on a first-name basis. And they respond to the needs that are communicated to them whether by an older individual or an agency representing large numbers of elders in a region of the state. If it were not for this contact, many older people would feel lost, isolated and alone when confronted by the governmental bureaucracies of Medicare and other programs. They, and we at the Area Agency, know that in addition to helping us resolve problems, Vermont lawmakers will listen to ideas and suggestions for improving and strengthening programs for older Vermonters from the State Tax Rebate to the Older Americans Act.

Area Agencies on Aging are appropriately charged with representing a Planning and Service Area (PSA) where the planning and advocating we do is done with as much commitment as providing or arranging for services to individual elders who are in need.

Section 306 (a)(6)D of the Older Americans Act describes the advocate role of Area Agencies as follows:

> 6 provide that the Area Agency will
> (D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect the elderly;

The National Association of Area Agencies on Aging (N4A) recommends deleting the word "community" to broaden the scope of advocacy to include state and federal actions as well and following this section with the phrase regardless of any prohibitions of OMB Circular A-122. I, and my colleagues here in Vermont, feel that this language is crucial to insert in Section 306(a)(6)D because, on the face of it, a proposed A-122 prohibition against using federal money to influence legislation is openly contradictory of federal policy articulated in the Older Americans Act in light of the advocacy role of Area Agencies on Aging.

This is even more of a problem in light of IRS regulations, due to take effect this Spring, implementing Section 1307 of the Tax Reform Act of 1976, "Lobbying by Public Charities". If A-122 took away our right to advocate to influence legislation with federal funds, the new IRS regulations would classify sharing practically any information with legislators or members of Congress as lobbying. Even the 20 percent expenditure rule (or 25 percent of that figure for grassroots lobbying) would be reached in no time if the exempt purpose expenditures did not include federal funds earmarked for "advocating" as well as service provision. Contrary to the statement in the Federal Register that these new regulations are not seen as a major rule-change requiring regulatory impact analysis, those of us who are small Area Agencies on Aging are beginning to realize that this is another reporting and paperwork requirement which will burden and hamper our efforts to advocate for elders. We will have to keep track of every minute of time we spend communicating with lawmakers or with elder constituents who might, whether or not we suggest they do, contact representatives as a result of reading information in a newsletter, bulletin, personal letter or other communication from the Area Agency.

If the provisions of OMB Circular A-122 and the new, drastically changed IRS regulations, were intended to focus on the abuse of large non-profit organizations in metropolitan areas who over-expand their funds on lobbying at the expense of otherwise serving a constituency which is in need of services, it will not be those agencies who feel the brunt of this new regulatory approach. Rather, small non-profits, including especially the smaller Area Agencies on Aging, will be crippled in their legitimate efforts to address the mandates of the Older Americans Act.

It is important to address the issue of advocacy versus services because, in the context of Area Agencies on Aging it is, in my opinion, a non-issue. On the one hand advocacy is a service we all are charged with providing; on the other hand, the record of Area Agencies on Aging in developing Nutrition Programs and other services over a span of twelve to fifteen years in most regions, when coupled with Older Americans Act maintenance of effort requirements, will assure that a natural check on the amounts spent to influence legislation, directly or indirectly through grassroots constituent empowerment, will exist within our network for the forseeable future.

While Area Agencies on Aging Directors in Vermont are very much in accord in supporting the exemption from OMB A-122 as far as influencing legislation is concerned, we would ask that this exemption be carried a step further for those of us who are non-profit agencies. We would also request an exemption, clearly stated in the reauthorization of the Older Americans Act, from the provisions of the Tax Reform Act of 1976, specifically the regulations which supersede Section 7.)(c)(4) of the Temporary Income Tax Regulations under the Tax Reform Act of 1976. We feel that there is ample precedent within the Older Americans Act, specifically the several references to the advocacy function and our role as a community focal point, for treating Area Agencies on Aging in a different manner than other public charities or non-profit agencies in this regard.

Thank you for providing this opportunity and inviting our comment on the reauthorization of the Older Americans Act.

Mr. **Jeffords**. This basically backs you up relative to the nutrition programs, on cost sharing and mandatory income eligibility, and also with respect to the prohibitions of OMB, and with respect to advocacy work.

Would you explain to me a little bit better whether you think that you really want to have a separate title for the advocacy work, is that a concern as to how you differentiate the Ombudsman Program, and whether or not we would end up either without having it funded or taking some flexibility away from pulling resources into a separate section on advocacy.

Would you explain a little bit better why you think that would be helpful, presuming that you do not get any more money overall. Because if it is on the presumption that you would get more money, that is fine too.

But I would just point out that our mandate is on the authorization side. We say what we think you need in order to run your programs well. And even at that, we have had to be much more reasonable on those areas in setting the authorization levels.

The appropriations level is what the Appropriations Committee sets after it takes a look at all of the various programs asking for funds.

So keeping that in mind, I wish that you would give me your thoughts on the recommendation for a separate subsection on advocacy.

Mr. **Hammond**. I believe that you are referring to the Ombudsman Program.

Mr. **Jeffords**. Well, I am not sure, having separate funding for the Ombudsman Program. I did not know whether you were trying to differentiate between advocacy or the ombudsman or not.

Mr. **Hammond**. We use the term advocacy with regard to——

Mr. **Jeffords**. I may be confused on that.

Mr. **Hammond** [continuing]. A certain kind of case work for people living in the community that is client centered and supports their certain rights and entitlements. It operates similarly but is not linked automatically and exclusively to the complaint resolution as the Ombudsman Program is. So we tend not to call the Ombudsman Program the advocacy program. It is an advocacy program.

Mr. **Jeffords**. Right, I understand. And I was trying to understand your distinction as to how you want to structure that in the statute.

Ms. **Dedam**. I think that advocacy could be looked at as more of a prevention type program. And because it is in home in the community, the purpose is to help individuals maintain independence as long as possible. And it does cover a wide variety of problem resolution, problem resolution more than complaint resolution. And assisting with the entitlement program is a major portion of it.

A person may be too frail to handle some of the chores that are needed around their home, or they may need an alternative housing situation, but they may not need at that point to be in a nursing home or a community care home.

The advocates help to assess the situation and provide information about the alternatives including what kind of in home care or respite care, all of the things that I am sure have been mentioned today. And it is a very important piece of our work. It helps with coordination of even some of the services where we do provide direct services.

If you want to look at the nutrition program and home delivered meals as a direct service, or transportation which is a major problem as I am sure you are aware in a rural state such as Vermont. And no matter what we do, we cannot seem to get away from that question also. So we do provide transportation services where there is no other resource, where no one else does provide it.

The advocate is there to give clients information about what is available to them and to hook them up with these services or individuals, knowing who the individuals are in the community that are available to help. They help with, you know, financial questions. And bringing in and connecting a senior companion for instance with a client who needs it.

It has been supported under the III-B portion of the Act. And that has been I would guess discretionary on our part as to how much of the resources under III-B that we want to put into advocate access. And it is an important part of the services and a primary part of the services that we provide. So of course, a lot of our resources go into it.

I have not been aware of a discussion about bringing advocacy as a separate program under the Act. And I think that in other parts of the country that advocacy is provided in a different way or not provided as a direct in home service that we do here.

Mr. JEFFORDS. Thank you.

Mr. HAMMOND. If I could just say one thing. I think that with regard to the Ombudsman Program as a Title III-D advocacy service, and that is the way that I have heard it talked about in these reauthorization discussions, to do that, it is my understanding hopefully, that would include some protected funding for the Ombudsman Program.

And at present, we borrow from Peter to pay Paul. We believe strongly in the Ombudsman Program. In order to fund a bare bones Ombudsman Program in the State of Vermont, we have to utilize Title III-B funds, and we use other funds as well. But we continually have to draw out of other III-B services in order to support that. And I believe that it should be a more protected program that it is.

Mr. JEFFORDS. Thank you very much. Mr. Kildee.

Mr. KILDEE. Thank you, Jim.

Mr. Hammond, you put your finger on probably the greatest congressional sin, and that is the disparity between authorizations and appropriations. That is true in so many programs. But the only area that it is probably not true is the Department of Defense. They come quite close to their authorizations each year. But it is a congressional sin.

Under new budget restrictions, we are getting closer and closer, because we are sometimes bringing the authorizations down rather than bringing the appropriations up in the social programs. Let me ask you this question. We talked about case management.

Would you support an amendment that would permit Area Agencies to provide case management as an access service without seeking a waiver from the state as required by the law right now? You raised some questions about the question of case management.

If we were to permit it, and you could do that without going to the state to ask for a waiver, would you support that type of an amendment?

Mr. HAMMOND. Yes, I would. To the extent that I do not believe in one sense that case management or care management is a direct service in the same manner that transportation, or respite or other kinds of things may be.

Mr. KILDEE. So you would accept that type of amendment?

Mr. HAMMOND. Yes.

Ms. DEDAM. Yes.

Mr. HAMMOND. And by waiver, you mean the direct service waiver?

Mr. KILDEE. Yes, right.

Mr. HAMMOND. Yes.

Mr. KILDEE. If such an amendment were enacted into legislation, do you think that Area Agencies would be availing themselves of that permissive case management situation?

Ms. DEDAM. Craig has already mentioned that there has been some discussions and consideration of case management in the state, what our role is, or could be or should be. And also the team approach with other agencies.

I believe that we would continue to work in a cooperative relationship with other agencies. But I am not sure that case management can be structured as a cooperation program. I am not sure how that could be structured under state legislation or federal legislation except on a voluntary basis.

And after having looked at what case management would require, it seems that we are in a good position to provide case management where we do not provide a lot of direct services because of our perspective. I guess that I would use a whole list of perspectives where we work with clients, and looking at all of their needs and are used to drawing on whatever resources are available to provide those needs.

And I think that we would definitely want to continue working in a cooperative relationship with other agencies. So I think that what I am saying is that we probably would avail ourselves of that option, but that it probably would not be an immediate thing, but it would be something that would have to evolve, and we would have to evolve carefully with it.

Mr. KILDEE. Would one of the considerations be that as your appropriations would increase for the entire program that this might move you more toward something like that?

Ms. DEDAM. Yes. Because I think that one of the concerns that we have had is in terms of case management that if we were doing intensive case management that a case manager would probably not be able to carry the same kind of case load that an advocate carries, in that case management tends to imply less preventive case. And that a person getting case management services is probably in greater need for a variety of support services than all of the people who are currently on an advocate case load.

And the advantage of having the advocate system is that you can work with people before they are in a great need and perhaps prevent that happening that soon, to maintain them in a healthier and more independent state longer.

And that is why I think that the system would have to evolve, and my feeling is that it would probably evolve as almost a dual system with maybe case managers and also advocates.

Mr. **Kildee**. Yes.

Mr. **Hammond**. One sentence. I just think that it is very important that case management be part of the Older Americans Act, that it be mentioned by name, and that it be recognized for what in fact has begun to develop nationwide without its specific mention in the Act as such. I just think that it is valuable to validate that and recognize that as a way to support it.

Mr. **Kildee**. But leave the option of its use pretty well on the local level, at the Area Agency level, or do you want to leave it at the state level?

Mr. **Hammond**. At least through this reauthorization, I would say that. I might come back the next time and say, well, we have come that much further now, now it is time, and let us nail this down.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. Thank you. And thank you for the excellent testimony again. And I tell you, we are getting some very, very good testimony this morning and we deeply appreciate it.

Our next panel is Cynthia Parsons of Chester; Faire Edwards of Montpelier; and Wayland Bowen of Richmond. If you would please come forward. Faire, go right ahead.

STATEMENT OF FAIRE EDWARDS, VERMONT CITIZEN

Ms. **Edwards**. My name is Faire Edwards, and I live in Montpelier. I am, I guess, a self-appointed advocate. First let me say a few words about case management. Crucifixion and subjugation, I cannot stand those two words. They mean a loss of control of the individual.

And if you must put it in, for God's sake give it a firm definition and change the wording. This wording has just sort of arisen, and it is in the class with poverty. It is something that you do not ever admit that you have got even if you have got it. But that is not what I came to talk about.

But while I am diverging, I would like to mention the matter of fees. I think that those fees would probably be cost effective, but only because they would hasten the deaths of the people. You would save a lot of Social Security that way, and probably quite a bit on Medicare.

But do you really want to do it? Because those fees are saying to people you are no longer a person able to control your life in your own right. You have to pay me in the coin of the realm to tell you what to do. You are invading their very souls. You are really putting them down.

Do you not know that the reason there are so many people who will not apply for assistance that they need and deserve is because they were brought up to know that if they loved the Lord and did their part that things could not go wrong. So if things go wrong, rather than accept the idea that they have fallen into poverty, they will deny reality. These are people's souls that we seem to tamper with.

I want to talk to you about the future. The first sheet of my testimony is the Vermont population by age and sex, a pyramid chart dated 1985 and that the Health Department got out quite recently. It shows a very astonishing pyramid that looks more like a Christmas tree except that it is getting squarer on top where you have all of those old ladies living longer.

And I have been greatly concerned about this for some time, because we are not really looking at the demography. Right now, anything that relates to human services should have every bit of its budgeting demographically focused. Because otherwise, it is just like saying that I go to Burlington and back on a tank full of gas, and therefore we are going to hold that and make me go to San Diego at the same rate. It is just as logical.

Anyway I have been greatly concerned both as a citizen of this state and as a citizen of this country by our lack of recognition of the demographic revolution and of the effect also of the war boom babies, the post-World War II baby boomers of which I produced I think three after the three that were born ahead, so mea culpa.

But the babies produced from 1945 through 1964 are, of course, going to start retiring in about 2010. And if we are not ready for that, we are going to be in deep trouble. I mean the rest of you are. I think that I will be watching from goodness knows where. But the rest of you are going to be in deep danger, especially the retiring ones.

To the dramatic increase in longevity, we have added a generation equal to nearly one-third of the population, and it appears that they will be followed by smaller generations, but you cannot be sure.

In the meantime, the old-old, particularly the old-old women, are squaring off the pyramid up around age 85 and older. So we are going to have more people in a group that is at risk.

I faced up to some of those things recently when I had my 75th birthday. It was just about the same time that I realized that I am now only 40 percent above the poverty level. I am pretty much holding still and poverty is moving along. This I do not like. But I was brought up differently, so I figure that it is not necessarily my fault. I just happened to hit in the wrong group.

I see no mention of addressing demography in the Older Americans Act. You people are, because it has been in your vocabulary, but it has not been in all of the things that we have heard.

There is a lot of talk about community care as a means of saving money rather than institutionalization. It sounds great until you look at the number of people available all hours of the day and night to give are.

Middle aged women are now working outside of the home because they need the money. And if anything happens to their marriage before they are old enough to get Social Security, they are not going to have any way to eat. Wives also often give home care to the husbands who then die anyhow. I mean this thing is weird. But who takes care of the aged widows.

As of 1990, the state is going to be I believe short 259 nursing home beds presumably in the area of Level II. That is the State

Health Department's own forecast, and presumably it includes all of the permissions that have been given in existence, the buildings that are already there, in addition to the buildings that are already there.

We have had a man working on a long-term care policy statement since 1980, and I have yet to see one that I consider sound in this state. For one thing, they forget to identify the population quite often, and that makes a great problem. But I am saying that you cannot rely on community care too much. Because the people who are the natural care givers are now getting promoted all too often up into the high risk category, because as widows they are living by themselves.

And I hope that you have been reading the Commonwealth Fund Commission on Elderly Living Alone. That is a very good thing. And when you have a study by Lou Harris & Associates handed to you by comments by Dr. Robert Butler, that is like somebody coming off the mountain with tablets in their hands anyhow. So I hope that they will come up with very good thinking.

Medicare and the prospective payment system for hospitals are steadily clamping down when budgeted funds are failing to care for a growing number of patients and higher costs.

Meanwhile home services cost more per patient in a rural area like Vermont simply because the population is more sparse and it is hard to get to some of the houses especially in winter or mud season.

That really makes a great difference. I have been concerned with human services in a suburban area and also in Vermont, and it is harder in Vermont.

All too often there is a lack of understanding by the general public nationally because the conservative groups have repeatedly publicized material slanted to make all old people look rich. They take the richest group of elderly which are couples immediately after retirement, figure out their incomes, compare to the poorest group of young people, and say gee, the old folks are rich.

What they do not look at are the people up here, the women up here 75 and up, who as a high percentage are living alone, because the husbands have died in a great many cases. I think that there is a 75 percent probability of women being widowed in the age group above 75. And they have less income.

Her 60 cents to his dollar goes all the way to the grave. I do not know how you gentlemen figured it. But you should get some women in there to help you decide what really is right, because we always have less.

Yet we have things like expenses for medications that may run over $1000 a year, prescription drugs to keep out of those darn institutions. And it is kind of hard to pay for them. Anyway you have the conservative groups trying to make us look richer than we are.

The public as a whole does not understand why so many of the old people have lived this long. Many factors have combined, but certainly the work of Louis Pasteur only a little over a century ago set in motion the growth of the science of bacteriology which along with other things has caused the demographic revolution. It is my feeling that the general public should know much more about how we happen to be surviving.

I can remember when I was a kid that germs were a big thing. Everybody was getting rid of all of the germs and painting their kitchens white. I am not quite sure what the connection was, but at least they could see the dirt. The younger people do not understand this sequence of a totally changed health situation.

Antibiotics were only available to the general public after the end of World War II, and that is why the World War II baby boom people are going to be a much healthier lot. Because they have had the benefit of medical technology far in excess of what we had when our only immunization for example was the vaccination. There are an awful lot of things that are no longer happening that did.

And we also have this great number of women. Some people think that we have been, oh, I do not know, saying a black mass or something. Actually, it was the maternal death rate that changed dramatically. I believe that it was something like 700 maternal deaths per 100,000 in 1930, and it was 17 in 1970.

That plus the Pap smear are the reasons that you have got all of us old ladies today. And I hope you like it, because you are stuck with us anyhow.

Please remember that we are the most individually diverse cohort in the entire population. And when these people who have come ahead of me have asked for flexibility, that is why they need it. Rural areas can also be very diverse.

Now what can Congress do? First, make some arrangement to inform the public about the demographic revolution. They honest to God do not know. How about giving the Federal Council on Aging some money and request that they arrange some way to do it. That could come under 204(d)(4). I would like to see them do something of that type. They are experts. They ought to be able to.

How about seeing up a special group on what the baby boomers expect to do in their years after age 65, and see how they figure things out. A lot of them have told me that they do not expect to retire at 65, but they are going to run into problems.

Your own committee could look into the laws of both state and federal government affecting employment after 65, and what its effects could be. A lot of younger people who reach that age may want to work part-time at one thing and seasonally at another, and also do jobs or limited duration. You know, finish up this task, make that survey, and arrange this new development, that kind of thing.

The health insurance problem connected with that type of employment is so far beyond the skills of the insurers. And what you have is if you have people working intermittently is you would have Medicare and the private insurer doing an Alphonse and Gaston act, each one saying after you, my dear, because they are very good at playing these games right now.

You do know, of course, that when Medicare out of budgetary reasons decides that you are not entitled to something, that also turns off your private insurance which is a blow. And if you cleaned up Medicare a little and the way that it is administered, that would be an act of great kindness before you get any more victims involved. Because eventually, some of these people are going to get really mad.

It sounds like a lot of work to do those things, but I think that you are going to have to think innovatively. And the work after normal retirement age is going to be a critical area. And things are being done about it, and people are thinking about it, and you probably know more about that than I do. I know that there is a vice president down at Travelers Insurance in Hartford who is very much interested.

But I ask you, please, that everything that you pass on, think about this darn chart. Put it under your pillow and dream about it. Because the more you think about it, the more frightening and the more challenging that it becomes. And that also applies to all of the people in Vermont. And if you want a copy of it, here it is. Thank you very much.

[The prepared statement of Faire R. Edwards follows:]

Prepared Statement of Faire R. Edwards, Vermont Citizen

Mr. Chairman, Members of the Committee
and Friends:

As some of you already know, I'm delighted to speak and thank you for the opportunity.

For some time, now, I have been greatly concerned because we, as a state and as a nation, are completely overlooking one of the most important happenings this country has ever experienced. We are having it in common with other developed countries but the United States alone seems to have added the post World War II baby boom. I am speaking of the demographic revolution which we confused further by having all those babies who will begin to reach retirement age in about 2010.

To the dramatic increase in longevity, we added a generation equal to nearly one third of the population. It appears that they will be followed by smaller generations, but you can't be sure yet.

If you will look at the most recent population pyramid chart of Vermont, you will see our problem. I am quite sure the rest of the country is not too different.

Each year before they retire the number of the old old... the people most at risk, is increasing. By the time today's 40-year-olds reach retirement, they should live longer than my generation (now 75) because they have always had anti-biotics and far more immunizations against diseases which we had to simply live through.

What's going to happen? There is no mention I could find in the Older Americans Act is it stands now.

There is a lot of talk about community care as a means of saving money. It sounds great until you look at the number of people available at all hours to give care. Middle aged women are working outside the home because they need the money now, and would need it more if their marriages end, for whatever reason. The wives often give home care to husbands, who tend to predeacease them. But who takes care of the aged widows?

Medicare and the prospective payment system for hospitals (D.R.G.'s) are steadily clamping down when budgeted funds are failing to care for a growing number of patients and higher costs.

Meanwhile home services cost more per patient in a rural area like Vermont simply because the population is more sparce and it's hard to get to some of the houses, especially in winter or mud season.

All too often there is a lack of understanding by the general public because the conservative groups have repeatedly publicized material slanted to make all old people look rich.

F. Edwards Pg 3.

True figures about the income of aged widows ~~is~~ are almost never given out by any official source and the actual numbers are hard to get.

Nobody has explained to the public why so many old people have lived this long. Many factors have combined but certainly the work of Louis Pasteur, only a little over a century ago, set in motion the growth of the infant science of bacteriology. Availability of electricity from the beginning of this century facilitated pasteurization of milk and improved refrigeration immensely. I remember well when the new diptheria shots joined vaccination against small pox. The others came later.

Anti-biotics came into general use about ten years after Social Security began. The speed of development of modern technology has been amazing. Most of our young people probably are not aware of it.

I would like to see an effort to let the general public know how it is that so many of us are now living so long. The reason women now live longer, is the improvement in maternal health care. Where nearly 700 women once died from childbirth, per 100,000 births in 1930, the number is now 17 per year. We not only survived to bring up the babies, but also to grow old later. The"Pap smear" also saved many women from earlier deaths, too.

It has been the custom to think of all people over 65, as being unemployable. To be sure, some elders have developed serious chronic illnesses that make full time work impossible. But most of us do want to be active and useful far longer. We have good age discrimination laws but they are not always well observed, especially if the worker relies on federal prosecution. In addition, some elders would like part time, or seasonal employment. Or specific jobs to accomplish a specific task. There is a big problem in health insurance. Both private insurers and Medicare will have to be trained and cajoled to set up a practical, workable system that keeps the intermittant worker protected. NOW is the time to get started on it.

Last, but not least, please remember that the old are the most individually diverse cohort in the entire population. Do not try to stereotype us.

Now what can Congress do?

1. Make some arrangement to inform the public about the demographic revolution. How about the giving the Federal Council on Aging some money and a request that they arrange some way to do it? That should come under 204 (d)(4)

2. How about setting up a special study group on what the baby boomers expect to do in their 65+ years and see how they figure things out? Many have told me they don't want to retire at 65

3. Your own committee could look into both laws (state and federal) affecting employment after 65-plus, and what its effects could be. There's a vice-president at Travelers' Insurance in Hartford, who is very interested in this.

Of course, I realize that this sounds like a lot of work, but, in the long term it can save a lot of time, money, and misery. Planning for the years 2010-30 must be done. Try it using the abilities of some concerned volunteers and you just might be very pleased.

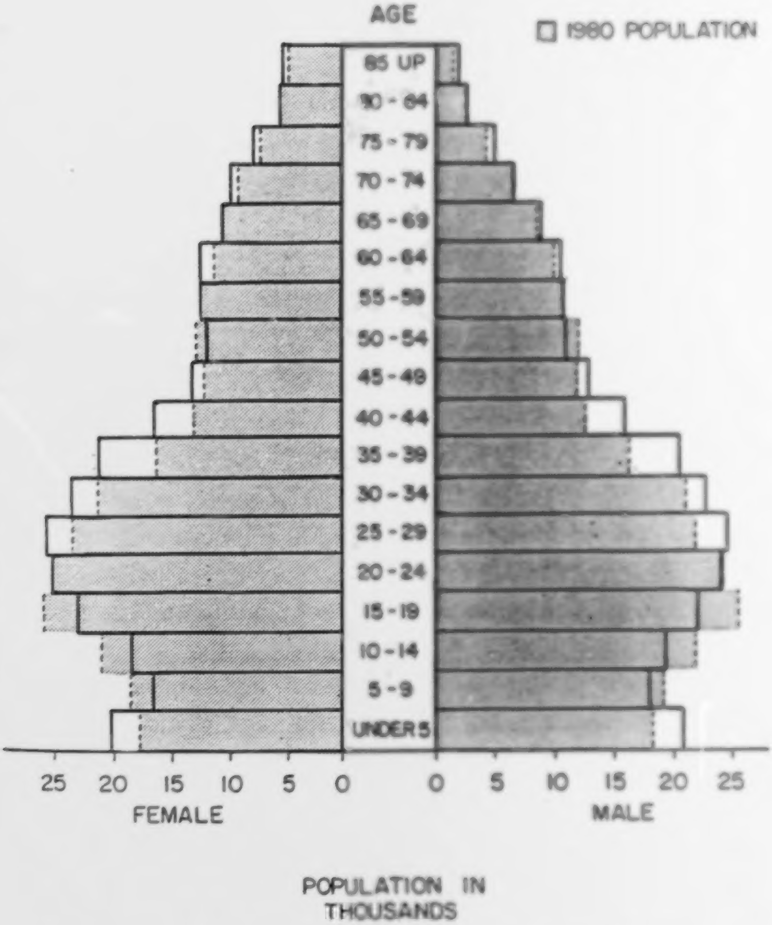
Respectfully,

Suggested reading:

Our Aging Society...Paradox and Promise, ed. by Alan Pifer & Lydia Bronte, Norton, 1986 copy by Carnegie Corp. of N.Y. Chapter One: Squaring the Pyramid.

Material from the Commonwealth Fund Commission on Elderly Living Alone, Chaired by Dr. Robert N. Butler
Commonwealth Fund Commission on Elderly People Living Alone, 624 N. Broadway, Rm. 4[illegible]2, Baltimore, M.D. 21205
(301) 955-3775

VERMONT POPULATION BY AGE AND SEX, 1985



From VERMONT DEPARTMENT OF HEALTH 1985 VITAL STATISTICS
Published March, 1987, Burlington, Vt.

Mr. JEFFORDS. Thank you, Faire, for a very perceptive and persuasive statement.

Wayland go right ahead.

STATEMENT OF WAYLAND BOWEN, VERMONT CITIZEN

Mr. BOWEN. Members of the panel, my name is Wayland Bowen, and I am from Richmond, Vermont, and I am 65 years old. I do not know much about these famous programs, because I have not paid much attention to them. They do not know anything more to me than they did when they were written.

I would like you to know about the President's State of the Union address where he was so interested in the financial problems facing the elderly Americans. And I guess that it was recommended by Dr. Bowen, no relation, thank God, because I do not know where he gets the $2000 out of pocket expenses that we can before we can go to the hospital and the government steps in. He is from the rich Bowens, I guess.

Now as being a former town service officer, I have seen a lot of these problems. I have taken people to doctors and brought them back, and things like that, and after they get there it is in and out.

For the very same simple reason that our President had two operations recently, today these people are not staying in the hospital for those same operations. It is out-patient. So we have seen both ends of the President on TV. I do not know which one I like the best.

But he has got to start thinking about us. And where we have made the mistake is that we have not organized like he has. I think that what we need is more actors down there, but we need some on our side.

If you want a good one, read one from Ann Landers about a women whose husband died out in Nebraska. And very few patients spend $400 a day in semi-retirement care. Who has got $400 a day on Social Security?

As many times as I have said it and it has been denied, we have got to put a one percent or a two percent sales tax, and I know that Congressman Jeffords disagrees with me. He says leave it to the states. We have that Gramm-Rudman shoved right down our throats, back to the states. The President did not raise taxes. That is the biggest lie in the world, because he made every state raise their taxes. That is a tax cut, baloney.

We have got to get a sales tax and have it for Medicare, Medicaid, and Social Security, and earmark it for that. It is hard to collect, okay. It is not hard to collect. If you put on a sales tax and have them pay it the same as they do the Social Security every quarter, and the first guy who does not pay it and you can prove him guilty, give him an automatic ten year sentence in the federal prison, and you will cut out the cheaters right off.

But you have got to do something for our elderly. We are going to be the majority the next time around, and I think that we better start organizing. Because the time is coming where most of us right here in this room are in our twilight years, and we ain't going to see many more.

So I am in favor of doing something for the elderly. You know, it is a shame that we are the greatest nation on earth and we are worried around the under-privileged nations, and we do not give a damn about the Americans starving to death. When we have got women right in the State of Vermont and men eating dog and cat food, because there is more nutrition in it than there is from government commodities.

And I have seen that right in the P&C in Burlington, where I asked this lady when she had so much dog food how many animals she had, and she said I have none, I eat this because it has more nutritional value by the federal government regulations than there is i the soup that is on those shelves. I could not believe here until I checked the cans, and she was right.

And I have a lot of pride in Vermont, and I do not like to see that. And I think that if we can give millions to anything else that comes up the pike no matter who cries wolf or anything else, and we cannot feed and house our elderly.

Gentlemen, please, go just one half hour to a nursing home in this area, and I beg every member of the Congress and Senate to spend one half hour in a hospital or a nursing home, and then please go vote your conscious. Thank you.

Mr. JEFFORDS. Thank you, Wayland, for a very excellent statement. I can assure you that I spend more than that each year in nursing homes, and it is an experience that all of us ought to have so we would understand better. I appreciate that very much. Thank you.

Our next witness is Cynthia Parsons, who has arrived now, and who has drove over an hour and a half to get here. And also, Marjorie Weiss, who is the President of the Alzheimer's Disease Association of Vermont. And Vivian Nemhauser who has asked to speak to us. So if you three would come forward, if you are here. I see that Cynthia is.

Again I want to thank all of those who have testified this morning. The reason that we come out into the field, as I mentioned earlier, is this is only one of a few field hearings on this important area, and therefore it is so extremely important that we get good testimony.

And it is from the people like we have been talking with today who will have probably more of an impact upon improvements of major legislation than anyone else. We can always have access to the national lobbyists with respect to the programs of the senior citizens, but we cannot always get members out into the field to listen, and that is why this morning is so important.

All right. Let us start then with Cynthia.

Ms. PARSONS. If I could have just half a moment.

Mr. JEFFORDS. We can go to Marjorie then. If you would like to start while Cynthia——

Ms. PARSONS. Collects herself.

Mr. JEFFORDS. Collects herself having driven an hour and a half to get here. We deeply appreciate that. But go right ahead, Marjorie.

STATEMENT OF MARJORIE WEISS, PRESIDENT, ALZHEIMER'S DISEASE ASSOCIATION OF VERMONT

Ms. **Weiss**. I am Marjorie Weiss, and I am the President of the Alzheimer's Disease Association of Vermont. I live in North Field, Vermont.

The ADAV has an interest in the Older Americans Act particularly as it applies to the allocation of funds for home and community based service for Alzheimer's disease victims.

We commend the Honorable James M. Jeffords and the committee for recognizing that there is a need for this type of assistance. This need is especially strong in the small rural State of Vermont.

In June of 1985, the ADAV used a survey questionnaire, well, two of them, to find out how many cases of Alzheimer's disease there were in the State of Vermont. One questionnaire was sent to neurologists, psychiatrists, family practitioners and internists. Those were chosen, because they would be the doctors who would be involved with the neurological testing, et cetera of Alzheimer's disease patients.

Another questionnaire was sent to the hospitals, these were the licensed ones within the State of Vermont, nursing homes, residence care homes and community care homes. The result of that survey can be seen on the attached questionnaire which nobody else has.

Mr. **Jeffords**. That is all right. We will make it a part of the record, and I can assure you that the staff and I will take a look at it.

Ms. **Weiss**. Some kind of home or community based respite care will be necessary in Vermont. Our survey indicated an estimated 2100 diagnosed cases of Alzheimer's disease, 1375 suspected cases in nursing homes, and 4500 physician treated cases of memory and mentation problems. That gives us an estimated total of 7975 Alzheimer cases in Vermont.

Half of the diagnosed patients are living and being cared for at home. All of those undergoing tests to determine the cause of their memory and mentation problems are living at home.

We need to keep these patients at home and out of nursing homes for health and economic reasons. To continue tending the needs of an Alzheimer's patient, I can tell you from personal experience, that the care giver must have some time off. The physical, emotional and mental stress is too great to be borne 24 hours a day seven days a week.

In rural Vermont where Alzheimer's patients and their care givers live in near isolation with little or no access to transportation, home and localized community based respite care services are desperately needed.

And this would be in addition. In order for those home and community based respite care to be used in the State of Vermont and to be used for Alzheimer's patients, training must be necessary for those people who would be going in to do it and work with that. An Alzheimer's patient is not your normal aged person. Thank you very much.

Do you have questions?

Mr. JEFFORDS. Thank you very much. We will wait until all of the statements are made before we have questions.

Cynthia, please go ahead. It is good to see you here.

STATEMENT OF CYNTHIA PARSONS, SERVERMONT COORDINATOR

Ms. PARSONS. Thank you. I am very grateful for the invitation from Jim Jeffords to come and both listen and present testimony before this distinguished and important committee.

For the past three years, after fourteen years as education editor of The Christian Science Monitor and an equal number of years as a classroom teacher, I have been exploring ways for our nation to provide a time of national service for all youth between the ages of 16 and 26, giving particular attention to the need to care for our senior citizens.

Just as we need a defense force made up of volunteers this age, so we need a human welfare force drawing on the energy, talents, enthusiasm, and career interests of this age group.

I would have the federal government provide post-secondary financial grants, ala the GI Bill, from what I call a Service Bill, rewarding 1000 hours of community service done after age 16 and before age 26 with a $5000 GI Bill like payment of post-secondary schooling. I would reward 2000 or more hours of community service with a promise of $10,000 of education funding.

But before the average American grows to consider as normal a period of national service, our schools need to support and encourage voluntary service by students.

Here in Vermont for the past fifteen months, I have been travelling from one academic secondary school to the next, 66 of then, suggesting that groups of students choose a member of the school faculty or administration and a local senior citizen to think through with them what the students could do to help improve the lives of the local rural elderly.

With private foundation money, SerVermont, as the initiative has been called, has been able to offer student groups up to $2000 to defray out of pocket expenses.

Two groups of students now offer to do household chores one request for any senior citizen in town. Three and possibly four student groups have invited seniors for a special meal at school combined with some special entertainment. Recently one high school held a Break the Winter Blues meal for local elderly.

A fifth grade class in tiny Concord, Vermont with one school for all grades adopted a ten bed senior home, and the students have not only visited with the residents, written to them, sent them cards and made cards for them to send to friends, but also sent along a tape recorder and some clear tapes asking the residents to tell what they remember being told about the Civil War when they were ten and eleven years old.

When all teachers in Vermont were offered an opportunity by SerVermont to apply for up to $3000 to defray expenses for a student community service project connected with course work, several excellent projects were chosen.

To cite just a few. Two schools, Bellows Free Academy in Fairfax and Canaan Memorial High, have students interviewing local elderly residents for the purpose of compiling local histories. Cabot High School is producing both a calendar and some post cards depicting scenes of young and old working and playing together in the community.

Students in Townshend from industrial arts, biology, and health classes are building both an aviary and an aquarium in each of the two local senior center/nursing homes. Health class students will study how the introduction of pets affect the seniors. Biology students will stock and maintain the environments, as well as carry out experiments with the help of resident observers. And, of course, the industrial arts students, with plenty of kibitzing we are sure, will do the actual construction.

I mention the actual projects because they are so exciting and innovative. Also because too many agencies when offered volunteer help by school students often offer jobs which keep the students too far removed from our older Americans.

Talk to these kids and they will tell you that what thrills them, if they delivery a Thanksgiving dinner to an older person living alone, is the look on that person's face when he or she sees the dinner. And it is that five or ten minutes of conversation that the youngster learns to appreciate the contribution of the older fellow community member.

Students can sweep floors, and file papers, and answer phones and carry messages around a building, but that is not what really helps our senior citizens, and it should not be the first use of these lively, fresh, exciting young people.

Too often our youngsters are asked only to help raise funds, and are never given the opportunity to suggest how those funds might be expended to meet the needs of the cause for which they have labored. Or too often they are asked to do menial chores, actually far removed from any direct contact or care.

Yet there is enormous evidence that contact with school age youngsters is a tonic of the first order for older citizens, particularly for those who live alone.

Let me suggest some program thrusts as you consider how the federal government can better serve older Americans. First, grants to school districts so they can provide essential funding for student groups with sound community service projects to meet one or more specific community needs, particularly for the elderly.

Second, grants to school districts so they can provide essential funding for one or more teachers who want to combine classroom work with student community service, particularly direct service to meet a local human need.

Third, grants to state departments of education to set up service funds to reward 10f00 or more hours of community service done by 16 to 25 year olds with up to $5000 in tuition credits applicable in approved post-secondary institutions.

Fourth, grants to local government agencies, for example, police, fire, parks, and recreation, so that they can initiate projects using student volunteers to improve community offerings for older Americans.

Fifth, funding for the placement of service agents, recruitment and counseling specialists, in each U.S. secondary school whose task it would be to fine local, state, national, or international placements in nonprofit service agencies for both in-school students and out-of-school youth up to age 26. Thank you. Cynthia Parsons, Chester, Vermont.

Mr. **JEFFORDS**. Thank you, Cynthia, for a very fine job. Vivian.

STATEMENT OF VIVIAN NEMHAUSER, DIRECTOR, SENIOR CENTER

Ms. **NEMHAUSER**. Thank you very much for holding this conference. I was not on the panel, but I could not help but making a few remarks. My name is Vivian Nemhauser. And having come all the way from Washington and Michigan, if you would like to meet a real live senior citizen who is a director of a senior center.

I am the director of the senior center in Bradford which is serving six towns which is about thirty miles east of here. I am not the Vermont delegate to the National Institute of Senior Centers under the National Council on Aging, and I have enjoyed meeting Congressman Jeffords in Washington.

I am also a veteran concerned with the increasing number of aging veterans. And as I come across elders in the senior center who are veterans, I also like to alert them as to the veteran facilities.

And I was much discouraged having received a $4000 cut in my budget because of Gramm-Rudman which is a 20 percent cut and not the 4.5 that we were expecting. And I could feel with sympathy when the VA hospital director complained also about being efficient, but he is small, and so the funds to go the larger groups.

I am here to push the idea of senior centers. I feel that they have been pushed in the background for other services. I think that senior services could greatly expand the services available to senior citizens by farming it out, dividing it up, and spreading it out more.

And I have been disappointed. I have been the director of the senior center for seven years. And I am disappointed in the lack of growth of senior centers in the area.

In our particular senior center, we use three of the SEP people, the employment program which is an excellent training program, and I would certainly hate to see that go. It has been a wonderful support to everybody.

We have the senior companion program under the Action program, three people. We have had two vans under the transportation program. And when Jim Cook was sitting up here, I thought that he looked a little lonesome without a senior citizen up here to answer some of the questions, particularly in transportation.

Because yes, transportation costs are high, but we live in a rural area. And every time I ask about my roads, and the fellow says yes, but do you know that we have got a hundred miles of roads to maintain. And when I asked for the RSVP program, they said oh, but you have so many miles out there. So I said, well, that is just for the cities. And she said, well, no, it is supposed to be for the rural.

So I think that the distances in travel are so important. And because distances are great, the more that you can concentrate services on different areas and senior centers in small areas, that you can scatter them around.

For instance, the Ombudsman Program. Instead of having one ombudsman for the whole big area, if we had a part-time ombudsman. Because in the Bradford area, we have one full-time nursing homes and we have four community care homes, and up and down the river there are other facilities.

So I think that in breaking things down into smaller packages and spreading them out more. And then with local funding you are able to expand those services.

Home delivered meals. There has to be extra funding for home delivered meals. We simply cannot do our home delivered meals out of our congregate meal costs, because there are costs of transportation. And I know that a state like New Hampshire administers a separate home delivered meals program.

There is a need for home delivered meals. But my, there is a need for increased congregate meals, because people just love to be able to come out and more and more they feel accepted. At first, they thought it was a charity. And I still have people say, oh, I will go if it is charity. And I say you can make a contribution.

But more and more as the people in the community come to the meals and they bring in other people. We have brought in people who would never have come to a meal before. And if you ask them for something. We ran out of funds, we ran out of USDA, and we had to ask people for $1.50 to make up the cost, and right away I lost the people.

So it is very important the donation system. And I have lots of people who maybe put in fifty cents. And on the other hand, you talk about the more affluent people. They will come and put in $2 or even $5, because they realize that there are other people in the program that cannot afford the program.

I do feel about the SEP program again, it is excellent. But we were hurt when they consolidated the offices. We used to have one representative from the Employment Service and a representative from the SEP in Bradford, and we have nothing now. In Berry, you have the SEP and you have the Vermont Employment Service. So we do not have anything.

So I do feel that these were some of the points. The in-home service, that was the last thing. Most important we found in our area, we got funding from the Independence Fund for a long-term care coordinator. And that was the greatest thing in bringing together the services.

We got the senior center, the community health services, the discharge plan from the hospital, and a representative from the hospice. And we learned to bring them all together. We somehow cannot seem to bring ourselves together. But more emphasis on funding a long-term care coordinator when I hear about case management and that sort of thing, even a part-time care coordinator who would bring these services together in the community, so that we are not stepping over each other.

We are working on inter-faith care givers, a long-term care givers group that will coordinate the churches in the area, again recruiting volunteers. So there is a potential for recruiting more volunteers in the area to support some of these services. If we have the structure that you can give us through the Older Americans Act. Thank you.

Mr. **Jeffords**. Thank you for a superb statement. It certainly focused on a number of the key issues on which we will concentrate on as we go through the reauthorization process.

Cynthia, your testimony was very enlightening and rewarding in the sense of the young people's participation. I know that I had the chance to visit the programs in West Germany some time ago where they have mandatory national service. And one of the programs that the young people enjoyed the most was serving and helping senior citizens to have more meaningful lives. And I know that there is a lot to do there that we have not done yet.

Marjorie, I think that we have all had personal experiences with Alzheimer's Disease with our friends and families. And I will tell you that there is nothing which is more difficult to be able to try and help people in that category. And I certainly admire your work in this area, and appreciate it very much. Mr. Kildee.

Mr. **Kildee**. Again I want to thank this panel. This is the first time that I have been in Vermont, and I have a feeling that it will not be the last time. I have learned a great deal here. I think that I will bring my family back next time, too. It is a beautiful state also. But I have really learned a great deal.

Ms. **Edwards**. If you enjoy it in mud season.

Mr. **Kildee**. Then I will really enjoy it in June.

Ms. **Edwards**. Do not let Jim fool you.

Mr. **Kildee**. I love it really. It is very nice, and has lovely people. And it is an area where you have unique needs and unique resources. And I have learned a great deal here today.

I was very interested in your statement on Alzheimer's victims, because it is an area that is going to grow in this country until we find some medical breakthrough on it. But in the meantime, we have to find some social breakthrough, so that we can take care of not only the direct victim, but very often the whole family can become a victim there, and I see that more and more.

I have authorized a new authorization or I put in a new authorization in the bill for the frail elderly that would cover those who are in that situation. But I think that is something that we have to address, as I said, not only medically but socially. It is a growing problem. And it brings so much sadness and illness say to the direct victim, but also a great deal of sadness, and burden, and consternation and bewilderment to others within the family unit.

And I would look forward to working with you, Marjorie, to try to address this in various ways. And I appreciate your testimony, and the testimony of all of you. Thank you.

Mr. **Jeffords**. Thank you, Mr. Chairman. As we bring these hearings to a close, I am just going to again thank Dale for coming to Vermont and assisting us with these hearings, and I know of his deep interest in this whole subject.

And also I would like to leave with him a little gift from the State of Vermont. This is now not only maple syrup but it is getting to be more like gold, because we are having more difficult and difficult seasons. My only concern is that after you have had this that your Michigan syrup will, of course, just pale in comparison. You will probably not want any more of that. But we deeply appreciate you coming.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. And also for the staff back here, we have little gifts for you, too. A little honey and syrup.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. Thank you all for coming. If there is somebody else who feels compelled to come down and enlighten us, please hold up your hand, and I would be happy to listen to you for a moment. Please come down.

In addition, we will leave the record open for another two weeks, if there is anyone who is here who would like time to collect their thoughts. Just send it to my office, and we will make sure that it is included as part of the record.

Please state your name.

STATEMENT OF HANNA COSMAN, VERMONT CITIZEN

Ms. **Cosman**. I am Hanna Cosman, and thank you for asking me to come.

Mr. **Jeffords**. It is good to see you again.

Ms. **Cosman**. Thank you. It is good to see you. I think that I am the only Jane Q. Doe, private citizen, who is not affiliated with any agency or care program. I am involved with a few such things, but very much on the fringe. I have a few questions.

If you send for instance to the Office of Management of Budget, is it is going to stay there or is somebody going to do something?

Also I would like to know whether the Older Americans Act concerns itself with just plain citizens who are either over 60, over 65, or over 75 like in my case who do not and I say "yet" need any of the services that all of the agencies provide?

Mr. **Jeffords**. I think that the answer to that is yes, it does. There are a number of programs that we have within the Older Americans Act and in addition to it that people who are over the age of 60 are eligible to participate in.

And one of the great benefits, as we discussed earlier, in the meals programs and the other programs that we have, such as the senior centers, is that they are available to people of all economic situations. They can come and share and help each other.

We have a volunteer senior citizen RSVP program and others that allow citizens to be able to participate. We have volunteer programs of senior people who were in business that help others who participate.

So the purpose is to allow everyone to have an opportunity to participate, and not just those who are in need, or not just those that are needy in the sense of economics.

Ms. **Cosman**. I am aware of that.

Mr. **Jeffords**. I know you are.

Ms. **Cosman**. There is a whole group of us who are living on the borderline, let us say income-wise who have assets. Medical bills are our greatest. Most of us who pay for Medicare and have compensatory insurance pay in the vicinity of $800 for that before we even see anything. Both programs, both Medicare and any comp program, there is a $75 deductible.

Somebody was talking about preventive medicine and Medicare which has nicely eliminated the reimbursement for Pap smears which would be preventive medicine instead of necessary medical services. And the list goes on, and on, and on.

What are you people going to do in Washington to put Medicare to rights especially in your area where the government handed the contract to the cheapest bidder who is the sloppiest business outfit this side of the Mississippi?

Mr. **Jeffords**. First of all, with respect to that—

Ms. **Cosman**. I am sorry that I cannot be any more polite.

Mr. **Jeffords**. No, you should not be, because those are important issues. In the New England delegation, I think that Vermont was the leader in asking the General Accounting Office for an investigation of the services that we are getting in our Medicare program right now. And it is a mess. You are absolutely right.

Secondly, we have a serious problem with Medicare coverage generally which we are trying to take care of. And that is the huge increase in costs by providers as time has gone on. And of course, the providers are upset by that. We are trying to find some way to keep the costs in order so that they do not keep progressing well above the cost of inflation.

And we have also put a cap, and I am sure that the Chairman voted for it as I did, on the deductibility, so that we do not have increasing deductibles for our senior citizens in the Medicare programs.

There are some serious problems with the President's recommendations on the catastrophic health insurance which we are taking a close look at to see what we can do to make that a better program. So there are a number of things that we are trying to do.

It is a tough problem. You have an expanding eligible age group and either a fixed or closely fixed amount of resources that are available for these programs. And we are fighting those issues out, and it is going to be a real rough fight by the end of the year.

But it is important that you highlight those, because if we do not hear screams—there is a tendency to put the money where the screams are.

Ms. **Cosman**. We have during our lifetime provided the means for this program, and are still providing them. If you get paid a $1000 a year, they take $70 out for Social Security, and the rest you pay for expenses and gas. And there, you do not gain anything. But the so-called one percent increase in COLA was completely wiped out for a good many Social Security recipients in the increase from the $15.50 to the $17.90 Medicare B.

Mr. **Jeffords**. Yes, I know.

Ms. **Cosman**. It is an endless thing of taking and providing less and less services.

Mr. **Jeffords**. Thank you so much.

Ms. **Cosman**. I will stop, and I will let you go home and have lunch.

Mr. **Kildee**. Thank you very much.

Mr. **Jeffords**. Thank you.

Mr. Chairman, with that, I will hand you the gavel.

Mr. **Kildee**. You can do it.

Mr. **Jeffords**. You want me to gavel it. Oh, my gosh, this is a rare experience. I formally declare the proceedings closed, except that we will hold the record open for another two weeks. And if anyone does have a statement, they may submit it to my office here in Vermont or mail it to me in Washington, and it will be included and made part of the record.

And again I want to thank all of the witnesses for superb testimony, and our very diligent assistant here recording every word for making sure that it is certainly available to us to study as time goes by. And I would like to thank my staff, Jay, Susan, Maurice, Joe and Linda, my district staff as well as my staff in Washington for their very, very informative and gracious help in making this a successful hearing. Thank you everyone.

[Whereupon, at 1:05 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Additional material submitted for the record follows:]

VITAL STATISTICS FROM THE SENIOR MEALS PROGRAM SURVEY

Note: All of the following tables are based on percentages; rounded off to the nearest whole number.

The 3 groups are referred to as:

H.D. - (seniors who receive home-delivered meals)

Cong. - (seniors who eat at Congregate Meal Sites)

No meals - (seniors who don't participate in the meals program at all)

1. Sex

	H.D.	Cong.	No Meals
Male	19%	27%	41%
Female	81%	73%	60%

2. Age

	H.D.	Cong.	No Meals
90+	11%	0%	0%
80-89	45%	17%	6%
70-79	26%	52%	33%
60-69	17%	31%	59%
100+	2 people	0	0
95-99	4 people	1 person	1 person
90-94	9 people	1 person	0

3. Marital Status

	H.D.	Cong.	No Meals
Married	24%	32%	75%
Widow/Widower	59%	52%	22%
Divorced/Separated	5	7	1
Never Married	12	9	2

4. Living Arrangement

	H.D.	Cong.	No Meals
Live Alone	59%	62%	20%

Where Do You Live:

	H.D.	Cong.	No Meals
My Own Home	44%	52%	82%
Rented Apt. or House	32%	16%	9%
My Own Mobile Home	5%	10%	7%
Subsidized Housing	11%	18%	2%

5. How did you first learn about the meals program?

	H.D.	Cong.
Relatives or Friends	46%	65%
All Media	5%	7%
Area Agency on Aging	25%	19%
Doctors, Nurses	23%	2%

6. How do you go grocery shopping?

	H.D.	Cong.	No Meals
Don't go at all	45%	2%	3%

How do you get to the doctors?

	H.D.	Cong.	No Meals
Drive myself	9%	50%	72%
Ride with family or friends	55%	30%	18%

7. How often do you talk or visit with friends or relatives? No real differences between the three groups.

Daily	73%
Once/Week	20%
Once/Month	3%

8. When you need help in an emergency, whom do you ask for help? No real differences between the three groups.

Friends	24%
Relatives	52%
Area Agency	3%
Doctors/ Nurses	14%

9. During the past year, how many days were you so sick that you had to give up some of your regular activities?

	H.D.	Cong.	No Meals
0 Days	21%	52%	51%
1-7 Days	16%	29%	20%
8-30 Days	21%	12%	14%
30+ Days	43%	7%	15%

10. Which of the following activities do you need help with?

	H.D.	Cong.	No Meals
Bathing	21%	3%	1%
Cutting toenails	40%	22%	8%
Reading	11%	3%	4%
Preparing Meals	40%	2%	1%
Climbing Stairs	28%	7%	7%
Going Outside	30%	2%	4%
Housecleaning	52%	18%	6%
Grocery Shopping	52%	10%	6%

11. Who prepares most of your meals?

	H.D.	Cong.
Myself	48%	74%
Household member	18%	14%
Friend or Relatives	6%	1%
Paid Help	4%	0%
Senior Meals Program	23%	8%
Restaurant	0%	2%

12. Food Stamps or cash-out program

31% home-delivered recipients on the program
18% congregate receipients on the program

9% home-delivered recipients don't know about the program
2% congregate recipients don't know about the program

13. Are you currently on a special diet prescribed by your doctor?

	H.D.	Cong.	No Meals
Yes	37%	29%	32%
What Kind:			
Weight Loss	5%	14%	6%
Diabetic	38%	21%	29%
High Blood Pressure	45%	46%	20%
Low Fat	7%	16%	26%

14. Do you receive income from any of the following sources:

	H.D.	Cong.	No Meals
Wages	3%	3%	14%
S.S. Disability	21%	11%	6%
SSI	25%	9%	5%
Social Security	73%	77%	84%
Other Retirement	12%	21%	38%
VA	8%	5%	5%
Investments/Savings	16%	23%	31%

How well does the amount of money you have take care of your needs?

	H.D.	Cong.	No Meals
Very well	20%	30%	36%
Fairly well	53%	55%	46%
Not very well	26%	14%	12%
Not at all	2%	1%	6%

Within the following ranges, indicate your total personal monthly income.

	H.D.	Cong.	No Meals
0 - $359	42%	26%	16%
$360 - $500	21%	25%	25%
$501 - $1,000	9%	19%	23%
$1,000+	0%	3%	14%
Don't Wish to Answer	24%	25%	18%

1. Other services received

	H.D.	Cong.	No Meals
Regularly have Home Health	33%	4%	--
Occasionally have Home Health	26%	10%	--
Never have Home Health	41%	87%	--
Regularly have Homemaker	13%	2%	--
Occasionally have Homemaker	10%	5%	--
Never have Homemaker	77%	93%	--
Regularly have shopping assistance	30%	10%	--
Occasionally have shopping assistance	18%	12%	--
Never have shopping assistance	52%	79%	--
Regularly have transportation	18%	15%	--
Occasionally have transportation	24%	19%	--
Never have transportation	58%	66%	--

2. Other activities participated in

Church	20%	55%	63%
Civic	2%	9%	20%
Fraternal	2%	12%	20%
Senior Center or Club	8%	67%	16%
Other	2%	6%	10%

3. Seasonal mobility

Spend winter in Vermont	98%	94%	92%

4. Years with program

less than 1 year	25%	10%	--
1 - 4 years	57%	60%	--
5 - 8 years	16%	30%	--

5. Frequency of Participation in Meals Program

How many Home-delivered meals per week?

	H.D.	Cong.	No Mea
one only	5%		
two	20%		
3-4	24%		
5	46%		
6-9	5%		

How many of the congregate meals do you attend?

	H.D.	Cong.	No Mea
Everyday site open		59%	
more than half		18%	
half		9%	
less than half		13%	

6. Non-Participants

Have you ever heard of the Meals Program?

	H.D.	Cong.	No Mea
Yes			94%
No			6%

7. How did you find out about Meals Program?

	H.D.	Cong.	No Mea
Friends or relatives	46%	65%	12%
Newspaper	1%	3%	40%
Radio	3%	3%	9%
Area Agency on Aging	26%	20%	7%
Poster-Pamphlet	1%	3%	5%
Doctor or Nurse	27%	3%	--
Other	1%	6%	31%

8. How do you rate the Meals Program?

Staff Helpful?

	H.D.	Cong.	No Mea
Yes	86%	97%	
No	7%	1%	
Sometimes	7%	2%	

Meal worth donation?

	H.D.	Cong.	No Mea
Yes	92%	94%	
No	1%	0	
Sometimes	7%	6%	

How do you rate the Meals Program? (continued)

	H.D.	Cong.	No Meals
Food tasty?			
Yes	82%	89%	
No	2%	1%	
Sometimes	16%	11%	
Food at proper temperature?			
Yes	80%	89%	
No	5%	1%	
Sometimes	15%	10%	
Served enough food?			
Yes	94%	95%	
No	2%	0	
Sometimes	4%	5%	
People make you feel welcome?			
Yes		98%	
Sometimes		2%	
Interesting activities at site?			
Yes		84%	
No		3%	
Sometimes		13%	
Able to eat all kinds of food served?			
Yes	79%	90%	
No	4%	2%	
Sometimes	16%	8%	
Did you believe there was a set price for the meal?			
Yes	14%	13%	
No	86%	87%	
Sometimes	1%	0	

9. How do you get to the meal site?

Walk	32%
Drive yourself	38%
Drive with family	14%
Senior vans or transportation	15%
Public transportation	1%

10. 1/3 of participants are on a medically prescribed diet. What kind?

	H.D.	Cong.	No Meals
Weight loss	5%	14%	6%
Diabetic	38%	23%	29%
High blood pressure	55%	53%	26%
low fat	17%	28%	32%
Other	17%	7%	20%

September 2, 1986

NEW FOOD DELIVERY SYSTEMS FOR OLDER PEOPLE IN VERMONT

As federal resources have stopped expanding, the Office on Aging and the area agencies on aging have developed new ways to deliver food services to elderly people at minimum cost.

1. COMMUNITY CONTRACTS

AAA's have worked successfully with community groups to develop volunteer or Community Contract sites. At these sites, the combination of participant contributions and the USDA reimbursement cover the entire cost to the AAA. Other costs, such as labor, rent, utilities are donated by the community.

Below are some examples showing how limited contract sites work.

SITE	NO.DAYS/ WEEK	AAA CONTRIBUTION	SITE CONTRIBUTION
Wells River	1	Raw food	All else
Peacham	2	Raw food costs	All else
W. Barnet	1	Raw food 1/2 heating bill	All else
Cannan	1	Raw food	All else
Greensboro Bend	1	Raw food	All else
Cathedral Square	1	Raw food	All else
Burlington Special Evening Meals	Several per month	Raw food	All else
Chittenden	Tuesdays	USDA reimbursement and Bonus Commodities	All else
Rupert	1	Cooks labor and food costs	Other labor, rent, utilities
Poultney	1	Cooks labor	All else
Fair Haven	1	Cooks labor	All else
Rutland Senior Center	Fridays	Food cost	All else
Sheldon Towers in Rutland	Fridays	Food cost	All else
Montpelier Senior Center	3	USDA Reimbursement Bonus Commodities	All else
Barre Fellowship Meals	3	USDA Reimbursement	All else
Newbury	2	USDA Reimbursement	All else
Weston	1	Raw food costs	All else
Peru	1	Raw food costs	All else
Charlotte	2xmonth	Raw food costs	All else
Leicester	2xmonth	Raw food costs	All else

2. SOS (Stock Our Shelves)

SOS grocery programs bring food to the homes of frail, isolated older persons who are not able to afford and/or transport food easily, but who can prepare meals given the "raw materials."

SOS programs can be set up by outreach workers or other professionals, with groceries purchased, packaged and delivered by paid staff. SOS could also be set up locally by selectmen, church or other local groups, and packaged and delivered by local store owner and volunteer.

CONTACT:

Margaret Dole, Nutrition Director
Northeastern Vermont AAA
44 Main Street, Box 640
St. Johnsbury, Vermont 05819
Telephone: 748-5182

or

Douglas Hall, Nutrition Director
Southwestern Vermont AAA
142 Merchants Row
Rutland, Vermont 05701
Telephone: 775-0486

3. COMMUNITY HELPER OR FRIENDLY NEIGHBOR PROGRAMS

"Community Helpers" are friends or neighbors of an isolated very frail senior who provide "meals plus" under contract with the AAA. The plus is the added value of neighborly visiting and concern and the special appeal of a home cooked meal Participants cannot prepare their own meals, as with the SOS Program, and are generally too far from a meal site to make home-delivered meals cost-effective. In some cases participants live close to a meal site which is only open a day or two a week and the community helper provides meals those days the meal site cannot cover. "Community Helpers" are often seniors themselves, and this gives added meaning to a program which strengthens community values and ties.

Locations: Contact Doug Hall, Southwestern Vermont AAA, 142 Merchants Row, Rutland, Vermont 05701 - Telephone (802) 775-0486, or Ronnie Freidman, Council on Aging for Southeastern Vermont, 139 Main Street, Brattleboro, Vermont 05301 - Telephone (802) 257-0569, or Craig Hammond, Central Vermont Council on Aging, 18 South Main Street, Barre, Vermont 05641 - Telephone (802) 479-0531 for more information.

Cost: Depending on contract; $2.00 to $2.50 per meal, with small allotment for mileage if necessary.

4. SENIOR MEALS IN SCHOOLS

Poultney Vermont is the site of the first school which has opened its doors to seniors. One day a week the school bus coordinates its noon run to pick up seniors and provide a lunch, and often a program is put on by students. The school receives the USDA $.56 reimbursement per meal and keeps the seniors donations. This pays for the cost of raw food and transportation to the meal. As the principal says "We can't afford not to do this with town support of our budget so critical."

Additional Information - Ronnie Freidman, Council on Aging for Southeastern Vermont, 139 Main Street, P.O. Box 818, Brattleboro, Vermont 05301 - Telephone (802) 257-0569.

5. SENIOR MEALS a la CART

"Senior Meals a la Cart" has served 800 meals since its 1985 inception on Church Street in downtown Burlington. Using an an attractive portable street cart (very much like a hot dog cart), Champlain Valley Area Agency on Aging staff offer seniors full balanced meals, information about the benefit programs, and a chance to sign up for other services. Diners range from older shoppers to a regular core of elderly very low income "street people," who have no previous contact with the area agency.

Cost: $1.55 per meal for food; the cart itself cost $200.00 to construct. It is staffed with volunteers.

Additional Information:

Contact: Lynn Willey, Nutrition Director or
Mara Coven, Director
Champlain Valley Area Agency on Aging
110 East Spring Street
Winooski, Vermont 05404
Telephone: 655-0084

6. THE DINER PROGRAM

Diner Programs have been developed in Morrisville, Burlington, Rutland, and Barre. Low cost meals are being served to economically disadvantaged seniors, who will not attend regular meal sites but will go to a local diner for a simple, hearty breakfast or lunch. Diner programs hav so far served about 7,000 meals.

Cost - Negotiable; usually between $1.75 to $2.50 per meal.

Additional Information

Contact:

Douglas Hall, Nutrition Director
Southwestern Vermont AAA
142 Merchants Row
Rutland, Vermont 05701
Telephone: 775-0486

or

Craig Hammond, Director
Central Vermont Council on Aging
18 South Main Street
Barre, Vermont 05641
Telephone: 479-0531

7. THE BREAKFAST SELF-SERVE

The Morrisville Senior Center provides a self-serve breakfast for participants who are volunteers and who come in early to peel vegetables, etc. These people generally spend most of the day at the Center, and would often come in without having breakfast first. It is a cost-effective and friendly meal service idea. The fare is made up of a crock pot of hot cereal, hard boiled eggs, juice, fruit, and milk.

Cost: Raw food costs only as the volunteers provide the labor and the Center is open during these hours.

Additional Information

Contact:

Chris Tricomi
Morrisville Senior Center
Morrisville, Vermont 05661
Telephone: 888-2288

or

Craig Hammond, Director
Central vermont Council on Aging
18 South Main Street
Barre, Vermont 05641
Telephone: 479-0531

/eg
9/4/86

HOME - DELIVERED MEALS STUDY:

WEEK OF OCTOBER 27, 1986

For the past 13 years, hot home-delivered meals have been available to homehound older Vermonters. To assess how well Home-Delivered Meals Programs are currently meeting the needs of Vermonter who are age 60 and up, the Vermont Area Agencies on Aging, in cooperation with the Vermont Office on Aging, tracked the delivery of meals during the week of October 27, 1986. A week record of the number of meals received by participants and their town of residence was collected at the 76 meal sites around the state which are the origination points for hoem-delivered meals. This information allowed us to explore the following questions concerning the Home_Delivered Meals Program:

1. In total, how many older Vermonters received home-delivered meals and, on average, how many meals did they receive during the week of October 27?

During the week of October 27, meal site staff throughout Vermont produced a total of 6625 meals which were delivered to 1416 frail older Vermonters. On average, each person received 4.7 meals that week.

How Many Additional Older Vermonters Could Use Home-Delivered Meals?

The results from the 1986 Needs Assessment of Older Vermonters (Vermont Office on Aging, unpublished) indicated that 8.8% (+ or _ 2%) of Vermonters who are age 60 or over and who do not live in an institution need help with meal preparation because their condition impairs their ability to prepare meals. According to Vermont Department of Health estimates, there were 79,844 non-institutionalized older Vermonters in 1985. If 8.8% of older Vermonters needed help with meal preparation, then we can estimate that there are approximately 7026 older Vermonters who need this kind of help.

According to the survey, of those who need help with meal preparation, 9.8% say they need more help. All of those who needed more help could not travel at all except in emergencies. Applying this percentage to the estimated 7026 older Vermonters who need help, it is estimated that approximately 690 older Vermonters need more help than they currently have with meal preparation.

In order to meet the need as estimated above, the number of weekly Home-Delivered Meal Program participants would need to increase by 690 people or 48.7%. This would bring the total weekly participation to 2106people.

In What Towns Was Service Not Provided? How Many People In Those Towns Could Use Home-Delivered Meals?

Out of 250 towns, 144 had Home-Delivered Program participants during the week of October 27. In 106 (42%) Vermont towns no one received home-delivered meals during this week.

It is estimated that 6335 older Vermonters who needed help with meal preparation lived in towns in which meals were delivered that week. Of these, 1416 or 22.4% received meals. It is estimated that in towns where meals were not served, 208 older Vermonters could have used home-delivered meals.

	Towns Served	Towns Not Served	Total
Number Who Need Help With Meal Preparation	6335	929	7265
Number Who Received Home-Delivered Meals	1416	0	1416
% of Population	22.4%	-	19.5%
Number Who Could Use Meals	482	208	690

Is There a Difference Between the Number of Older People in Towns With Service as Compared With Towns Without Service?

Towns with home-delivered meals service have larger populations of Vermonters age 60 or over than towns without service. (Average of 479 people as compared with 98 people, respectively.) Most often participants are concentrated in the area closest to the meal site where meals are prepared for delivery (see list of towns in Appendix A). It is not surprising, therefore, that residents of small towns which are less likely to be able to support a meal site are also less likely to have access to home-delivered meals. In addition, in smaller towns, meal sites that do exist operate less frequently, and therefore, meals are not available as often

In What Locations are Program Participants Not Receiving as Many Meals as They Need?

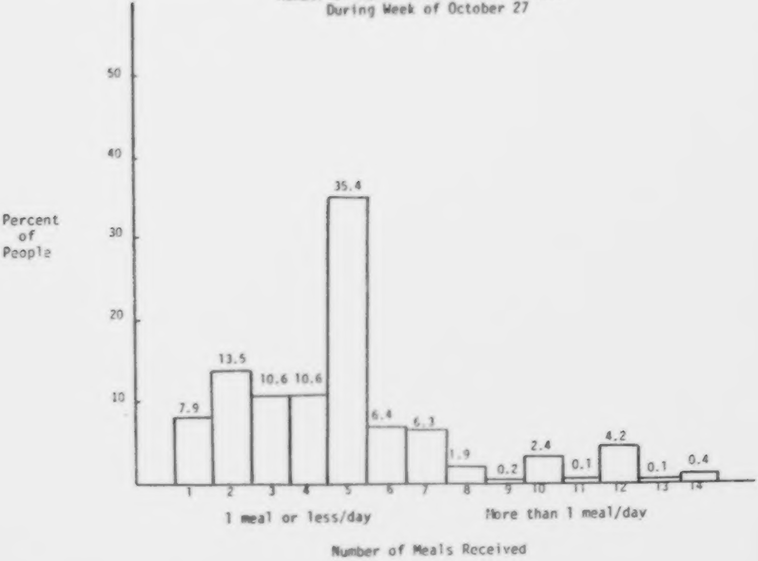
Older Vermonters who live in towns with smaller populations in general, and smaller older populations, on average, have real deliveries on fewer days and receive fewer meals.

	Town Population		
	1-499	500-999	1000 & Up
Number of Towns	109	21	14
Number of Participants	544	291	566
Number of Meals	1439	1049	2536
Average Number of Weekly Deliveries	2.6	3.6	4.5
Average Number of Meals Received	3.7	4.4	5.8

Summary

To serve the statewide 7 meals per week to estimated 690 people statewide who need more help with meal preparation but are not receiving meals and the 1416 people who now receive 4.7 meals per week would cost an additional $1,453,400 based on a meal cost of $3.25.

Number of Meals Received Per Person
During Week of October 27



"...on behalf of the residents..."

VERMONT OMBUDSMAN PROGRAM REPORT

1986

VERMONT OFFICE ON AGING
WITH
AREA AGENCIES ON AGING

MADELEINE KUNIN
GOVERNOR

JOEL COOK
DIRECTOR, VOA

PATRICK FLOOD
STATE OMBUDSMAN

INTRODUCTION

1986 was a dramatic year for Vermont's Ombudsman Program and the residents of long term care facilities. Area ombudsmen handled a record number of complaints. Important legislation affecting residents was passed. Recruitment and training of volunteer/assistant ombudsmen became a reality. The first printing of the Vermont Ombudsman Handbook became available for consumers. And significant involvement by consumers and residents in the Ombudsman Program increased.

The Ombudsman Program is mandated by the Older Americans Act (see appendix A). Ombudsman responsibilities, simply put, involve: individual advocacy, issue advocacy, disseminating information, and promoting community and consumer involvement both in the ombudsman program and long term care. This report is organized into those four categories.

The Ombudsman Program consists of the State Ombudsman in the Vermont Office on Aging and five area ombudsmen, one in each Area Agency on Aging.

The Vermont Office on Aging contracts for these ombudsman services with each Area Agency. Each Area Agency is a private nonprofit organization, and area ombudsmen are supervised employees of the Area Agency.

The State Ombudsman has responsibility for developing the statewide program: coordinating efforts, developing priorities, providing technical assistance, and monitoring local programs to insure they are in compliance with relevant law and programs policies.

Ombudsmen services are free and confidential. Protecting residents' confidentiality is required by Federal law, and breaching that confidentiality is allowable in only certain specific circumstances. They are:

1. With the informed consent of the client.
2. When ordered to by a court.
3. With regard to abuse and neglect of older persons, under federal law ombudsmen may choose to share that information with a law enforcement or public protective service agency. However, under Vermont law, ombudsmen are not required to share such information without the consent of the resident.

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INDIVIDUAL ADVOCACY

"...investigate and resolve complaints made by or on behalf of...residents..."

Area ombudsmen handled 464 complaints in 1986, from 290 unduplicated complaints.* As the attached charts indicate, most of these complaints involved patient care and patient rights. Roughly 40% involved nursing homes, 33% residential care homes, and the remainder involved unlicensed facilities, responsible parties, agencies, etc. Over 300 complaints were verified or substantially verified; roughly 100 were undetermined; 43 were unjustified.

What is a complaint?

The Ombudsman program Policies and Procedures defines "complaint" as: (a) "any reported problem which affects a resident or residents of a facility (nursing home, residential care home, illegally unlicensed facility, or other insitution) concerning its operation, condition, personnel, care or treatment; (b) any infringement of a resident's rights, or misuse of resources by a guardian, power of attorney, friend or relative; (c) any failure of an agency or service provider involved in the long term care system to carry out its responsibilities as set down by law or the agency's policies."

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*Complainants often have more than one complaint concerning different aspects of long term care.

Examples.

1. Two elderly residents of a nursing home, who attend a day care program are arriving unkempt, and one with his urinary catheter improperly attached. The program director has brought this to the facility's attention, but the problem continues. The director calls the area ombudsman who resolves the problem in discussions with the nursing home staff.

2. An ombudsman visits a nursing home resident in response to a complaint. She is with the resident a few minutes when the facility social worker enters the room and states she wants to sit in on the meeting. This is clearly a violation of the resident's right to privacy. The ombudsman brings this to the facility administrator, who agrees it won't happen again.

3. The daughter of a nursing home resident asked the facility director to provide her mother, who is not able to sit up straight, with a reclining chair. The administrator told her he would look into it. A week later she hasn't heard anything, so she calls the area ombudsman for assistance who contacts the facility and the resident receives a reclining geri-chair.

4. A resident tells the ombudsman that she has a guardian, and has asked the guardian to put $1500 into a burial fund. The guardian hasn't done this and the resident asks the ombudsman to help. The ombudsman calls the guardian who requests a formal letter. The ombudsman sends one on behalf of the resident, and the fund is established.

OMBUDSMAN PROGRAM COMPLAINT STATISTICS FY 1986

COMPLAINTS	CVCOA	CVAAA	NEAAA	SECOA	SWAAA	TOTALS
# OF COMPLAINTS	131	139	50	48	96	464
% OF STATE TOTAL	28.2%	30.0%	10.8%	10.3%	20.7%	100.0%
# UNDUPLICATED	71	89	37	28	65	290
% OF STATE TOTAL	24.5%	30.7%	12.8%	9.7%	22.4%	100.0%
# VERIFIED	80	92	38	25	63	298
% VERIFIED	61.1%	66.2%	76.0%	52.1%	65.6%	64.2%
# NOT JUSTIFIED	12	19	2	1	9	43
% NOT JUSTIFIED	9.2%	13.7%	4.0%	2.0%	9.3%	9.3%
# UNDETERMINED	39	18	6	20	24	107
% UNDETERMINED	29.8%	12.9%	12.0%	41.7%	25.0%	23.1%
OF COMPLAINTS VERIFIED						
# RESOLVED	51	75	28	23	24	201
% RESOLVED	63.7%	81.5%	73.7%	92.0%	38.1%	67.4%
# NOT RESOLVED	14	15	8	2	37	76
% NOT RESOLVED	17.5%	16.3%	21.1%	8.0%	58.7%	25.5%
# WITHDRAWN	6	0	1	0	5	12
% WITHDRAWN	7.5%	0.0%	2.6%	0.0%	7.9%	4.0%
# REQUEST NO ACTION	16	10	4	1	15	46
% REQUEST NO ACTION	20.0%	10.9%	10.5%	4.0%	23.8%	15.4%

	CVCOA	CVAAA	NEAAA	SECOA	SWAAA	VOA	TOTALS
CASES	36	120	73	20	79	N/A	328
REQUEST FOR SIMPLE INFORMATION/QUICK ADVICE	201	324	179	201	344	35	1149
PUBLIC INFORMATION (PRESENTATIONS, TRAININGS, NEWS ARTICLES, RADIO/TV SHOWS	13	10	13	18	13	17	84
VOLUNTEER HOURS	147	96	150	20	341	N/A	

OMBUDSMAN PROGRAM

COMPLAINT STATISTICS FY 1986

COMPLAINTS INVOLVING:

		#	%
1.	NH:	181	39.0%
2.	CCH:	153	32.9%
3.	UNLICENSED:	19	4.1%
4.	OTHER (BENEFIT PROGRAM AGENCY, DOCTOR, GUARDIAN/DOA, HOSPITAL, FAMILY)	111	23.9%
TOTAL		464	100.0%

OMBUDSMAN PROGRAM

COMPLAINT STATISTICS FY 1986

COMPLAINTS BY ISSUE:

Abuse/Neglect/Exploitation	46
Access	3
Administrative	48
Against an Agency	9
Against Family	14
Against a Benefit Program	4
Against Guardian or Power of Attorney	18
Bed Holding	1
Medicaid $1 Co-payment	11
DRG's	1
Facility Conditions	24
Food Service	27
Inappropriate Placement	11
Long Term Care Insurance	7
Long Term Care System	7
Mandatory Reporting	3
Medicaid Discrimination	1
Medications in III/IV	3
Patient Care	102
PIL/CCH	7
PNA/CCH	17
PNA/Nursing Home	2
Resident Rights	78
Staffing	10
Theft/Missing Items	8
Training	1
Transportation	7
Unlicensed Facility	1

Issue Advocacy

"...monitor the development and implementation of Federal, State and local laws, regulations, and policies with respect to long term care facilities:"

"...collect and analyze data relating to complaints and conditions in long term care facilities for the purpose of identifying and resolving significant problems..."

Ombudsmen receive many complaints which cannot be resolved without changes in law or regulation. Such problems affect large numbers of residents and their families, and are usually complex. In last year's ombudsman report, six issues were identified by the Ombudsman Program as affecting residents and their faimiles the most: Medicaid discrimination in admissions practices; lack of intermediate sanctions; lack of policy for holding beds for residents who must enter the hospital; inappropriate placements; inadequate staffing; and lack of mandated allowance for personal spending money for residential care home residents.

Of those six, four were addressed to some degree in 1986:

(1) A full range of intermediate sanctions were established by the legislature. When a facility has problems but revoking the license is not in the best interest of residents, one of several intermediate sanctions can be used to bring a facility into compliance. These include civil fines, suspending new admissions, transferring residents, and receivership.

(2) If a resident needs hospitalization, and is a Medicaid recipient, Medicaid will not pay the nursing home for the resident's bed and also pay for the concurrent hospital stay. Most of the time this is not a problem, for nursing homes will hold a bed empty for a few days. If a facility does not, however, it creates a hardship for the resident who must move to another facility upon discharge from the hospital.

Now, as part of the recently enacted Patients Bill of Rights (see below) residents have the right to return to the first available bed in the nursing home they came from after hospitalization. This provision minimizes stress for the resident, and doesn't cost the nursing home or Medicaid extra money.

(3) Ombudsmen receive complaints that people requiring nursing home care or residential care are inappropriately placed in illegally unlicensed facilities, that is, facilities which should have a license. These illegally unlicensed facilities too often receive referrals from providers and agencies. A change in the facility licensing laws, attached to the intermediate sanctions bill, provides that agencies and professionals (a) must not knowingly place a client in an illegally unlicensed facility and (b) if they have reason to believe a facility is operating illegally, must report the facility to the licensing agency.

(4) Most residential care homes allow their residents who are SSI recipients adequate personal spending money after paying their monthly bill to the home. Some homes, however, do not, and a few take the residents entire SSI check, leaving them no

spending money for personal needs..

While this is a complex issue involving operators claim that SSI payment levels are inadequate, leaving residents no or little spending money presents serious financial dilemnas for residents and affects their personal dignity.

The legislature passed a measure calling on the Agency of Human Services to promulgate regulations to assure residents of adequate personal spending money. The Agency of Human Services is developing a study of the issue.

(5) One of the major pieces of legislation affecting residents was the Nursing Home Patients Bill of Rights. This bill did several things:

(a) Incorporated rights in federal regulation into Vermont statute.

(b) Added four rights, including the one mentioned in #2 above.

(c) Provided that residents receive a notice of their rights in clear, readable language.

(d) That same notice be posted in a conspicuous place in each facility.

(e) That residents be informed of the facility's grievance procedure

(f) That residents be informed how to contact the ombudsman if they wish.

What are current issues?

1. Residents and advocates are still pressing for an increase in personal spending money for nursing home residents. Currently Medicaid recipients are allowed $25 to meet personal needs. This amount has not changed in over ten years.

2. Staffing in nursing homes is one of the most frequent consumer complaints involving patient care.

3. Inadequate training of nursing home aides is another frequent consumer complaint.

4. Residential Care Home residents could benefit from the kind of Bill of Rights with notice and grievance provisions and information about ombudsman that nursing home residents now have.

Information

"...to provide information as appropriate to public agencies regarding the problems...in long term care facilities..."

Providing information takes two forms: to other agencies, and to the public. The Older Americans Act does not specifically charge ombudsmen to provide information to the public, but without doubt it is one of the most important things we can do. Consumers who have some understanding of the long term care system have fewer problems later, and are better prepared to handle problems themselves.

1. Information to other agencies.

This year the Ombudsman Program developed a memo of understanding with the Adult Protective Services Program (Elderly Abuse) to spell out among other things, the proper referral process and guidelines for information sharing.

A similar memo of understanding with SRS licensing (level IV homes) is in draft form and under discussion.

Work will begin on a memo of understanding, with the Department of Health in 1987.

The Ombudsman Program operates under strict confidentiality guidelines which prevents sharing of some information. But within that framework we can develop several vehicles for sharing information that regulatory agencies should be aware of. The most important vehicle is a clear referral process so that complaints of a regulatory nature are referred, with permission, to the proper agency. If an ombudsman resolves a problem, the regulatory agency should know the problem existed and how it was resolved.

2. Information to consumers.

The Ombudsman Program continues to utilize various media to educate consumers:

a. The single most important informational development in 1986 was the Ombudsman Handbook. Written with input from Area Agencies on Aging, regulators, and providers, the Handbook provides basic information to consumers anticipating entering the long term care system.

The Handbook will be updated at least yearly. Program eligibility guidelines will be updated as needed by the use of inserts.

The Handbook is available from area ombudsmen in the Area Agencies on Aging. They are primarily intended for residents, prospective residents and their families.

b. The State Ombudsman writes a monthly column for the Senior Herald on issues and concerns in long term care.

c. The State Ombudsmen and area ombudsmen completed a total of 84 public information efforts including newspaper articles, radio shows, public service announcements, trainings and inservices.

d. Besides the above efforts, Ombudsmen testified before several committees of the legislature on the legislation described in the previous section.

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CONSUMER AND COMMUNITY INVOLVEMENT

"...provide for training of staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program..."

"...in planning and operating the ombudsman program, consider the views of area agencies on aging, older individuals, and provider agencies;"

As outlined above, the primary responsibilities of the Ombudsman Program are individual advocacy and issue advocacy. But individual advocacy is more successful when ombudsmen can also enable and empower residents and other consumers to advocate for themselves. Issue advocacy is more successful when relevant parties join in discussion and coalitions.

1. **Volunteers** not only assist the area ombudsman, they represent a grass roots level involvement in the program. Volunteering or assisting in ombudsman work is not for everyone; it requires knowledge, patience, tact and persistence. But the difference one individual can make in the quality of residents lives is enormous.

Volunteer/assistants in the Ombudsman Program are not intended to be friendly visitors. Rather, by making regular contact with residents, a volunteer/assistant can provide information, explain a resident's rights, or encourage a resident to voice a grievance. The volunteer/assistant can follow-up on problems to be sure the resident is satisfied.

Volunteers/assistants may choose to be certified to handle complaints and solve problems. In order to be certified, the volunteer/assistant must: complete a trial period; take two initial days of training; pass a test; receive a good recommendation from the area ombudsman; and attend all regularly scheduled trainings. Volunteer/assistant are supervised by the local ombudsman and must refer certain complex problems, such as allegations of abuse, to the area ombudsman immediately.

Volunteer/assistant hours in 1986:

2. **The involvement of consumers and the community** in the Ombudsman program and long term care began in 1985 with the development of the state Ombudsman Advisory Board. For 1986, efforts were begun around the state to develop local groups.

The Central Vermont Council on Aging ombudsman continues to work with the social worker at McFarland House on an "executive" resident council. The council has discussed how residents might have input on issues that affect them. They also are working on a video discussing "what makes a good aide from the resident's point of view" to be used for orientation.

The ombudsman in the Council on Aging for Southeastern Vermont began a long term care support group for concerned consumers in the Springfield area. The group meets monthly to hear from knowledgeable persons in the long term care field and discuss ways to promote effective, positive change.

The ombudsman in the Southwestern Vermont Area Agency on Aging began recruiting residents and providers for a local advisory board. This board would have input into the local program, be a forum for discussion, and a vehicle for promoting change and legislation.

In several instances, individual complaints have led to ombudsmen meeting with groups of local consumers. In such cases, the Ombudsman Program's policy is to encourage consumers to address problems themselves to the degree they can, and then involve the ombudsman. This entails giving the consumers information they need, such as regulations, which regulatory agency to contact, the most effective ways of addressing complaints. (For example, Ombudsmen have a form complainants can utilize to make sure their complaint is presented in a complete, organized fashion.) In such cases ombudsman often act as mediators as well as advocates, working to improve dialogue between consumers and providers.

3. The State Ombudsman Advisory Board continues to meet at least quarterly, and board members have recently decided to try to meet more often.

A slightly revised goal statement and list of board members is attached (see appendix B).

More resident and consumer representation is needed, and this will be a priority in 1987.

In 1986 the board discussed:

a. A survey of nursing home aides.

The State Ombudsman decided to postpone the Survey indefinitely because of perceived reluctance to participate on the part of a significant number of facilities.

b. The Elderly Abuse law and facilities responsibilities to educate employees. The board recommended the Ombudsman Program work with the Adult Protective Services Program to promote and particpate in such educational efforts, which was done.

c. A grant to provide training for nursing home staff on mental and emotional health problems of residents. The grant was completed and submitted to the Retirement Research Foundation and the independance Fund. Unfortuantely, it was rejected by both.

d. A policy and procedure for utilizing volunteers in the Ombudsman Program.

e. The Patient's Bill of Rights. The board suggested wording and organization for the notice to residents.

f. The board organization purpose, in an effort to strengthen the board and increase its effectiveness.

MISCELLANEOUS ACTIVITIES

1. Alzheimer's Disease

Alzheimer's disease affects the long term care system dramatically, and the Ombudsman Program has been prominently involved in developing a statewide organization, the Alzheimer's Disease Association of Vermont. The State Ombudsman was elected Chairman of the Baord of ADAV and has contributed significant time to organizational and educational projects. The Vermont Office on Aging has contributed support staff time and other in-kind support (e.g., mailings, copying) to the organization.

The Council on Aging for Southeastern Vermont also works closely witn two local Alzheimer's support groups.

2. "Taking Steps".

The Vermont Health Policy Corporation has a current project of holding statewide public discussions on the issues of critical and terminal care and the questions and dilemnas families, patients and caregivers often face. The project is called "Taking Steps: Ethical Decisions for Living and Dying.'"

The State Ombudsman serves on the Advisory Board to the project, and is the discussion leader for discussions held in nursing homes. Seven discussions had been held in nursing homes by the end of 1986, and more planned for 1987.

APPENDIX A

Older Americans Act

(12) provide assurances that the State will—

(A) establish and operate, either directly or by contract or other arrangement with any public agency or other appropriate private nonprofit organization ~~which is not~~, *other than an agency or organization which* is responsible for licensing or certifying long-term care services in the State or which is ~~not~~ an association (or an affiliate of such an association) of long-term care facilities (including any other residential facility for older individuals), a long-term care ombudsman program which ~~will—~~*provides an individual who will, on a full-time basis*—

(i) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare, and rights of such residents;

(ii) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities in that State;

(iii) provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities;

(iv) provide for training *staff and* volunteers and promote the development of citizen organizations to participate in the ombudsman program; and

(v) carry out such other activities as the Commissioner deems appropriate;

(B) establish procedures for appropriate access by the ombudsman to long-term care facilities and patients' records, including procedures to protect the confidentiality of such records and ensure that the identity of any complainant or resident will not be disclosed without the written consent of such complainant or resident, or upon court order;

(C) establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems, with provision for submission of such data to the agency of the State responsible for licensing or certifying long-term care facilities in the State and to the Commissioner on a regular basis; ~~and~~

(D) establish procedures to assure that any files maintained by the ombudsman program shall be disclosed only at the discretion of the ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long-term care facility shall not be disclosed by such ombudsman unless—

(i) such complainant or resident, or his legal representative, consents in writing to such disclosure; or

(ii) such disclosure is required by court order; *and*

(E) in planning and operating the ombudsman program, consider the views of area agencies on aging, older individuals, and provider agencies; . . .

APPENDIX B

STATE OMBUDSMAN PROGRAM ADVISORY BOARD

State Ombudsman	Patrick Flood
Department of Health	Carolyn Harris
SRS Licensing	Rolland Gerhart
Area Ombudsman	Muria Roberts
Senior Citizens Law Project	John Michael Hall, Esq.
RCHA	Robert Volks
VHCA	Norman Girouard
DSW	(to be named)
AHS Long Term Care Planner	Don Horsley
Adult Protective Services	Steve Antell
Department of Mental Health	Beth Edgar
Residents	Dorothy Heath
	Catherine Hutchins
At-Large	Dr. John Bell
	Dr. William Deane

APPENDIX C

COMPLAINT CATEGORIES

CATEGORY	COMPUTER ABBREVIATION
Medicaid Discrimination	M/A DISCRI
SSI Discrimination	SSI DISCRI
Residents Rights	RIGHTS
Abuse/Neglect	ABUSE/NEGL
PIL/CCH	PIL/CCH
$1 Co-payment (CCH)	CO-PAYMENT
PNA/CCH	PNA/CCH
Inappropriate Placement	INAP/PLAC
PNA/Nursing Home	PNA/NRSG
Bed-holding	BED HOLD
DRG's System	DRGS
Long Term Care Insurance	LTC INSUR
Staffing	STAFFING
Staff Training	TRAINING
SNF denial (NH's)	SNF DENIAL
Unlicensed facility	UNLICENSED
Transportation	TRANSPORTA
Medications in CCH's	MEDICATION
Mandatory Reporting	MAND REPTG
Long Term Care System	LTC SYS
Against family	AG. FAMILY
Against Power of Attorney or Guardian	AG. POA/GUA
Against Benefit Program	AG. BENPROG
Against Another Agency	AG. AGENCY
Administrative	ADMINISTRA
Patient Care	PAT CARE
Food Service	FOOD SERVE
Facility Conditions	FAC COND

REAUTHORIZATION OF THE OLDER AMERICANS ACT

Part 2

SATURDAY, APRIL 11, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Flint, MI.

The subcommittee met, pursuant to notice, at 1:40 p.m., in the Michigan Room, University Center, University of Michigan, Flint, Michigan, Hon. Dale E. Kildee presiding.

Members present: Representatives Kildee and Sawyer.

Staff present: Susan Wilhelm, staff director; Tom Kelley, legislative associate; Carol Lamb, minority associate.

Mr. **Kildee**. The Subcommittee on Human Resources will come to order.

I welcome all the witnesses this afternoon as we meet to discuss the reauthorization of the Older Americans Act, an act that has had strong bipartisan support in the Congress for many years. Older Americans Act programs provide the lifeline that enable the elderly to live independently in their communities, whether it be transportation services, homemaker services, congregate or home delivered meals, participating in senior center activities or even finding employment through the community service employment program. The Older Americans Act provides opportunities that enable the elderly to continue to be active participants in their own communities.

The Older Americans Act and the programs it authorizes are among the most successful of any federal programs currently operating. Although older persons may receive services under many other federal programs, this act is the major vehicle for the organization and the delivery of social services to this group. The fact that the act has been overwhelmingly reauthorized many times since it was first authorized in 1965 attests to the strong bipartisan support that it enjoys, as well as to its effectiveness.

I appreciate the opportunity to talk to people today who are really involved in this success story because it's people like yourselves who have made it successful. And I want to thank you for proving that Congress can respond to a real need and create a program that truly benefits individuals, families, and our society as a whole. I've seen many programs, worked on programs, which have not quite convinced me that we reached the goal we tried to achieve. This is one of the programs in which I see success wherever I go throughout the country. I want to thank you people for it.

I sought out the chairmanship of the Human Resources Subcommittee last Congress because it gave me an opportunity to take a more active role in programs for which I have a very deep concern, particularly those affecting the elderly. As I approach my responsibilities on this subcommittee, I try to bear in mind the words of one of my heroes, Dr. George Washington Carver, the great black educator, scientist, who founded Tuskegee Institute. He said, "How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and strong because some day in life you will have been all of these." If we're lucky and fortunate, we'll all be old some day.

I've always believed the government's role is to promote, protect, defend and enhance human dignity. I examine every bill that comes before the Congress of the United States with that in mind. Will this promote, protect, defend and enhance human dignity, or will it tend to denigrate human dignity. Whether it's a school lunch program, Meals on Wheels, Older Americans Act, aid to the contras, MX, I try to apply that principle to it. And certainly the Older Americans Act really meets those goals of promoting, protecting, defending and enhancing human dignity.

I look forward to hearing our witnesses here today, and I am very pleased that we have joining us the Congressman from Akron, Ohio who drove up here for the hearings, Congressman Tom Sawyer. Tom?

Mr. SAWYER. Thank you, Mr. Chairman.

I didn't have such noble purposes in seeking to be a member of this subcommittee. To tell you the truth—he does not know this—one of the reasons I wanted to serve on this subcommittee was the opportunity to work with Congressman Kildee. And if that embarrasses him, good. [Laughter.]

It is very much a pleasure for me to be here with you all today. The community that I seek to represent, Akron, Ohio, and which I represented in our state legislature, and just prior to this as mayor, is a community not unlike this one, that has been in many ways at the heart of what has made America a strong and productive place. Together we can repay a kind of excellence that has been given to my generation by a generation that came before is to sustain the quality of life that has been earned and strengthen it, and pass it on to those who follow. If we can do that through the kind of standard that the Chairman has set forth, why, it will be a great pleasure.

So, with that, I am going to stop talking and start listening because I find I learn more that way. Thank you.

Mr. KILDEE. Thank you very much.

We also have with us the Majority Staff Director, Susan Wilhelm, who puts these bills together after we finish the hearings around the country; and Carol Lamb, who is on the minority staff in Washington, DC. We are pleased they are here today.

Our first panel consists of Clarice Jones, Immediate Past President, American Association of Retired Persons; and Olivia, Libby, Maynard, whom we all know here in Flint, Director of the Michigan Office of Service to the Aging; Keith McCall, Executive Director of the Michigan Coalition on Aging Organizations; and Hollis

Turnham, State Long-Term Care Ombudsman. Would they please come forward to the table?

STATEMENT OF CLARICE JONES, IMMEDIATE PAST PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS; ACCOMPANIED BY SCOTT MARSHALL

Ms. JONES. Good afternoon, Chairman Kildee, Subcommittee member, Mr. Sawyer, ladies and gentlemen.

I am Clarice Jones, past chairperson of the A.A.R.P. board of directors. On behalf of the association's more than 24 million members, I would like to share with you some of our recommendations regarding reauthorization of the Older Americans Act, particularly regarding the advocacy mandate. Scott Marshall is accompanying me today to assist with any questions you may have.

In order to foster maximum independence, the mission of the act has been to provide a range of services to those older person with the greatest economic and social need. A.A.R.P. has a number of specific recommendations it believes would facilitate better service to all of the nation's elderly. However, because of time constraints, I would like to refer you to the Association's recommendations in the written statement, which has been submitted. These recommendations range from redesignation of planning and service areas to gerontology centers, Title V, and inter-agency coordination of programs with those of the act.

One major concern of the Association is the need for improved advocacy on behalf of older persons by the Administration, the states and area agencies on aging. Legal services under the act is a critical component of that mission. Older persons not only have the same legal service needs as the general population, they have additional legal service needs due to their unique health, income and social status. Their dependence on a network of services provided by government bureaucracies with changing regulations, guidelines and procedures makes affordable, competent legal assistance crucial to protecting their rights.

A.A.R.P. believes that legal services for older persons should be reauthorized as a priority service under the act because many area agencies on aging can provide little or no legal services. The law should be amended to require spending at least six percent of funds under Title III(b) on each priority service. It should be clear that six percent is not interpreted as a ceiling, but simply to insure adequate funding.

Congress should also authorize a private right of action for procedural violations of the act covering both service providers and program beneficiaries.

Finally, the Association recommends reauthorization of section 424 of the act with a separate $1 million authorization for the legal assistance organizations mentioned in section 424(a)(1) of the act.

Chairman Kildee, legal services do not represent all of A.A.R.P.'s concerns on advocacy. We also have detailed recommendations in the text of our written statement on the ombudsmen as advocates.

In conclusion, A.A.R.P. urges prompt reauthorization of the Older Americans Act. Our suggested changes to the act and its administration require little statutory change, but greatly improved services for all older Americans. The elderly of our nation deserve our most careful attention to this important legislation.

I thank you very much.

[The prepared statement of Clarice Jones follows:]

TESTIMONY

OF

CLARICE C. JONES
PAST CHAIRWOMAN OF THE BOARD OF DIRECTORS

ON BEHALF OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

U.S HOUSE OF REPRESENTATIVES SELECT COMMITTEE ON AGING

REGARDING

REAUTHORIZATION OF THE OLDER AMERICANS ACT

APRIL 11, 1987

For further information contact:

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TESTIMONY OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT

PRESENTED BY CLARICE C. JONES

Good afternoon Mr. Chairman, ladies and gentlemen.

I am Clarice C. Jones, Past Chairmanwoman, AARP Board of Directors. On behalf of the Association's more than 24 million members I would like to outline some trends in aging in America, and share with you some of our recommendations regarding reauthorization of the Older Americans Act.

For over twenty years, the Older Americans Act has served as the sole federal social and community service statute designed exclusively for older persons. In order to foster maximum independence, the mission of the Act has been to provide a range of services to those older persons with the greatest economic and social need. As Congress deliberates the many issues of reauthorization under the Act, it is important for the aging community and policy makers to consider demographic and social trends in aging. This will allow us to frame our policy recommendations not just around immediate needs, but also the needs of older persons in the future.

Size and Growth of the Older Population

Everyone is aware of the rapid growth in the nation's older population. What is startling about the aging trend today is the rapid pace. In the last two decades alone, the 65 and over population grew by 54 percent while the under 65 population increased by only 24 percent. In 1940 there were just over 20 million persons 55 years of age or older and about 9 million over age of 65. By 1980, the number of persons 55 and over increased by 141 percent and those 65 and over by 183 percent.

Increases in these two populations pale when compared to increases in the oldest age groups, those 75 and over. The number of persons 75 and over has increased by more than 275 percent between 1940 and 1980. This trend is expected to continue into the next century. By the year 2035 every fifth American will be 65 years of age and over.

As the older population has increased, there has been a substantial shift in its sex and racial composition. Since 1940, women 55 and over constitute a greater proportion of the older population. The survival rate for women at age 65 is 30 percent greater than men of the same age. As a result, older women now outnumber men three to two. Census projections indicate that by 1990 there will be 11.3 million women 65 and older who will be single and living alone, compared to approximately 8 million today. These changes will have a great impact on the demand for income supports, social services, and health care.

The increase in the number of older minorities has also contributed to the significant growth in the older population. The number of older persons who are members of minority groups has increased faster than the number of older white persons. By the year 2025, the portion of older persons who are minorities is projected to increase 75 percent compared to a 62 percent increase for the white population. Older minorities, however, will continue to comprise a smaller group in absolute numbers than older whites.

Major changes in public policy will be essential to coping with the effects of the changing numbers in different age groups. Presently, there are about twenty persons 65 years and over for every hundred persons of working age. After baby-boomers turn 65 around the year 2030, however, this ratio is expected to double. Such variations in the dependency ratio will have a significant impact on the provision of adequate housing, health and social services, employment, and social security due to the decline in the number of workers to support such publicly-funded programs for older persons.

The Older Americans Act program can respond to the needs of this changing older population in a variety of ways:

o Health and Long Term Care

As the incidence of frailty, disability, and chronic illness increases in a growing older population, the OAA can play an important role in the development of a comprehensive coordinated system of health and long term care services. While most older persons are somewhat healthy and active in their early retirement years, health and mobility decline with age. Important issues for the future will have to focus on health service needs and cost containment, including services designed to help older persons function within their own homes.

The problems associated with rising health care costs will continue perhaps beyond this century. As this occurs, we need to pay equal attention to access and quality of health and medical care.

o Income Maintenance

The provision of adequate income for older Americans is one of our greatest challenges. An adequately funded and expanded Title V program is essential to meet the employment needs of older Americans. While there is a growing perception that the economic status of older persons has improved significantly, when the cash income of the elderly is compared to that of the young working population, there remains a substantial discrepancy. While the proportion of elderly poor has dropped by two-thirds since 1959, our future concern must focus on how to meet the public costs of income maintenance for older persons given the increased older population, expanded longevity, and inflation. In order to stretch limited resources we must continue to focus on building public and private program structures that increase retirement income opportunities, particularly those serving older persons with lower incomes.

o Housing

Few issues will be more important to the future well-being of older people than their living environments. Adequate supportive service programs under the Older Americans Act such as homemaker, friendly visitor, and chore services are essential to prevent premature institutionalization of many older persons. Expanding and strengthening such services will be essential to a properly designed housing policy in the future and may contribute in saving public resources expended on older persons. Current demographic projections indicate that the number of households headed by older persons is steadily increasing. More than one-fifth of all U.S. households are headed by persons 65 and over and this figure will rise by 33 percent in 1995. As the proportion of older persons increases, particularly the frail elderly, the dominant issue will be how can we design and implement interventions to assist older persons in coping with their housing and independent living needs.

o Social Services

Much of our success in meeting the future needs of our older population will lie in our ability and willingness to strengthen provisions under the Older Americans Act. As funding for social service programs declines in the face of increasing demand, the Older Americans Act, as the focal point for federal assistance to older persons, becomes even more critical. The present system is plagued by fragmentation, duplication, and ineffective coordination efforts at all levels. Increasing life expectancy will have major implications for the way we must revamp our human service delivery systems. Coordination will be critical if we are to adequately address the needs of older persons in extremely varied circumstances and with varying levels of need. This means that the Act should continue to target services to special populations while providing sufficient flexibility to state and local agencies to meet local needs.

The following are some of our specific recommendations that directly affect the most vulnerable and disadvantaged elderly persons. AARP believes these needed improvements in the Act would facilitate better service to all of the nation's elderly population.

Extension of the Older Americans Act and Heightened Visibility of the Administration on Aging

AARP strongly believes that the legislation should be extended for at least three years. This would enable service providers and others to make long-range plans and to chart their activities more effectively. Morever, it would still allow appropriate congressional committees to perform oversight responsibilities. Also, because many programs have operated with no increased funding or cuts, AARP will continue to advocate adequate funding for all programs under the Act, especially those targeted to vulnerable populations. This could be achieved through authorization of such sums as necessary.

The Older Americans Act and subsequent amendments make clear that Congress intended the Administration on Aging (AoA) to be a highly visible and strong advocate for the aged. However, AoA is currently a subunit along with several other agencies (such as the Administration on Children, Youth, and Families or the Administration on Developmental Disabilities), within the Office of Human Development Services at the Department of Health and Human Services (HHS).

The net impact is that AoA has not fulfilled its intended role because of its lower status in the HHS organizational structure. We strongly believe that the aging agenda should be elevated within HHS by having the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

Advocacy, Coordination, Facilitation, and Care Management Roles of Area Agencies on Aging (AAAs).

The role of Area Agencies on Aging (AAAs) as service providers by contrast to their role as facilitators/coordinators and advocates is a major concern of the Association. Congress recognized when the law was enacted that there would always be insufficient funds under the OAA to serve all eligible elderly persons. In order to maximize the benefit derived from each OAA dollar, AAAs should be required to reaffirm their commitment to a coordination/facilitation/advocacy role. The current requirement to justify direct provision of services to older persons in the state plan needs stronger emphasis, and more attention needs to be placed on coordination, facilitation and referral. Although there may be a need in some situations for AAAs to assume the role of service providers, use of OAA funds for service delivery should not take priority over the ability of AAAs to perform the coordination mandate of the Act.

AAA involvement in case or care management should be considered only in the context of the above comments and recommendations. Additionally, it should be noted that in situations where the AAAs become the direct deliverers of service, there is great potential for conflict of interest between their marketplace provider role and their statutory role to facilitate, monitor, and advocate.

In light of these concerns, it seems appropriate that AAAs be involved in case or care management only as part of a carefully controlled demonstration that includes a broad array of other non-profit entities besides AAAs. The exception would be where other providers (private and non-profit) are not responding to the need for services.

The demonstration sites should be selected on a competitive basis. Each demonstration applicant should submit a plan for activities and intended outcome. Periodic evaluation of plan implementation and outcomes would be required. Demonstration costs should not exceed a specified reasonable amount.

Opposition to Consolidation of Funding for OAA Programs

AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. Further, the Association opposes consolidating funds of different programs under the same Titles within the Older Americans Act. For example, we favor separate authorizations for (1) supportive services and senior centers, (2) congregate meals, and (3) home-delivered meals. We fully recognize that a single authorization would make it easier for state and local offices on aging to submit funding plans. It would also provide great flexibility for offices on aging. However, these "administrative convenience" arguments are outweighed by other considerations. First, separate authorizations for supportive services, congregate meals, and home-delivered meals enable these programs to maintain greater visibility. This, in turn, has produced more realistic appropriations, especially for the nutrition program.

Second, there is already flexibility to shift funds under Title III. For example, 30 percent of the funding for the nutrition program for the elderly can be transferred to supportive services and senior centers, and vice versa. Moreover, up to 15 percent of the nutrition appropriations can now be shifted between congregate meals and home-delivered meals. AoA approval is required if a larger percentage is needed. In fact, there has already been a significant transfer of Title III funds.

Third, consolidation of OAA program funds with other OHDS monies or consolidation of program funds under the Act itself makes services to older persons more vulnerable to a block grant. This would certainly mean less funding to services for older Americans, and especially aged minorities. For example, before elimination, only a tiny fraction of revenue sharing funds were used for services for the elderly. In addition, block-granting is usually a prelude to program cuts. With ever increasing numbers of older persons, cuts could not be more ill-timed.

Redesignation of Planning & Service Areas

In order to avoid jurisdictional disputes and possible service disruptions, AARP questions the advisability of any proposal to expand the authority of AoA and the states to redesignate planning and service areas. Ample authority already exists to change planning and service area boundaries when necessary.

Opposition to Raising the Age for Allocation of Funds Without Taking into Account the Needs of Special Populations

An allotment formula is used in computing the amount of federal money each state will receive under the OAA. Any proposal to raise the population threshold for allotment of funds under Section 303 from age 60 to age 70 should take into account the service needs of special populations (such as minorities, frail elderly persons, and the rural elderly poor) who do not meet the arbitrary age threshold for the allocation of funds. A formula change which targets additional funds to states with higher concentrations of persons over 70 as proposed by the Administration, may be justified because of the increased costs in serving this group. However, the Administration's proposal, unless modified, would set a dangerous precedent for ignoring the real health, nutritional, and social needs of those in their sixties who are presently served. Not only does this create an inconsistency by having a formula based on 70 when the program serves persons at age 60, it ignores the special needs of minorities who depend more upon services to the elderly between ages 60 and 70 and statistically do not have a 70-year life expectancy. Although those minorities reaching age 70 typically live as long as the general population, inadequate health and other factors in earlier years contribute to lower life expectancies. Our concern should focus not only on those who manage to survive to age 70, but to assure that as many as possible live as long as possible. Indeed, need for service should be the factor weighted most heavily in any effort to revise the allocation formula.

The Association believes that the current formula for allocation has served its usefulness and we should begin exploring new alternatives that reflect future realities of aging. A more effective allocation formula would weigh four criteria. Highest weight would be assigned to economic need, followed by social need (minority and age 75+), then rural, and finally those over age 60. Such a formula should be phased in over the length of the next reauthorization of the Act and should include a hold harmless clause for funding to states. This would ensure that no state suffers cuts but redirects any new funds to areas of need. Intra-state allocations should also reflect this formula change.

Finally, 35 states would lose money under the age 70 based formula until 1991 when most are expected to approach or slightly exceed current funding levels. Given the demand, our emphasis should be to reverse this negative association between funding and growing need.

Fee-For-Service Under the Older Americans Act

The proposal that states and AAA's be given the option to set sliding scale fees for service raises concern about the following:

(1) voluntary contributions or mandatory payment for services;

(2) payment based on income; and
(3) adequacy of current cost sharing contributions mechanisms.

AARP has traditionally supported voluntary contributions emphasizing non-aggressive solicitation of contributions from those who could afford to pay. State and area agencies believe that a sliding scale fee would permit coordinating OAA program services with other services that are means-tested in some way. There would be no fee for referrals, outreach, advocacy and Ombudsman services. What is not clear is which services (e.g., health, transportation, homemaker, legal, meals, chore on companion) would be subject to contributions and how the rates would be set. There should be protected groups that would be exempt from fees such as those with incomes less than 125% of the poverty standard. Unfortunately, some evidence suggests that declining participation by minority and low income populations results from a perception that a voluntary contribution is actually a charge for service.

AARP continues to support a policy of voluntary contributions for service. We recommend that no broad fee-for-service plan be adopted prior to a carefully monitored demonstration where the impact on minorities and low income elderly populations can be ascertained. In such a broad, multi-state demonstration, emphasis should be placed upon non-aggressive solicitations, self-reporting of income, and no direct or indirect coercion. Solicitations for contributions should occur after the service is rendered, and consideration should be given to exempting the contributions requirement altogether for legal services. Even then there should be uniformity among the states as to which services are exempt from contribution, although states should have the option to charge a fee for nonexempt services. Only after we have devised ways to ensure fair fees that do not deter those most in need should the policy be expanded to a national one.

Minority Participation under the OAA

Due to the dramatic decrease in minority participation rates in OAA programs, the Association urges that stronger statutory language should be incorporated in Title III to promote increased participation by aged minorities in services programs. Older minorities receive about 18 percent of services under Title III of the Act. But their participation rate is nearly twice that level in the Title V Senior Community Service Employment Program (SCSEP). In fact, minorities constitute about 40 percent of all Title V enrollees. Minority participation rates under Title III have declined every year except one from FY 1980 to FY 1985.

Findings of the 1982 Minority Elderly Services Report by the U.S. Civil Rights Commission concluded that while older minorities participated to some extent in all Title III programs, there were some services where minorities were consistently absent. Minority persons often felt that OAA programs were not responsive to their needs and priorities; meals were not culturally appropriate; non-English publications were seldom available; and there was insufficient publicity about OAA programs and referral services. Outreach to minority older persons by AAAs was poor, and minorities were absent or excluded from the service delivery planning process on local advisory councils. A final reason for lower minority participation was the failure of state offices on aging to monitor the civil rights compliance of local offices on aging. The Commission report noted underrepresentation of minority contractors under Title III and low status for minorities working in AAAs.

AARP believes that the OAA should require state plans to include reasonable assessments of aging minority needs. Moreover, they should be served on the basis of their need for service rather than their proportion of the overall population. State Units on Aging and AAAs should engage in appropriate outreach efforts to include liaison with community organizations concerned with the needs of minority elderly persons. Additionally, the Association urges that the OAA should require federal, state, and local offices on aging to take affirmative steps to promote opportunities for minority employment, training, and contracts. The aging services network, we firmly believe, will be more effective in responding to the special problems and challenges confronting older minorities if more minorities are employed in decision-making positions and as service providers. More bilingual personnel should be hired to serve limited-English-speaking older persons.

Documentation of efforts to serve older minorities should also be required. The Commissioner should be given the discretion to withhold some reasonable sum from the state where it consistently fails to meet modest goals outlined in the state plans on service to elderly minorities. The Commissioner would then contract for services to targeted minorities or authorize the state to contract for such services.

Finally, it is essential to encourage more minorities to enter the field of aging because there is a dearth of adequately trained minority professionals and para-professionals in gerontology.

Legal Services Under the Older Americans Act

Older persons not only have the same legal service requirements as most other Americans, but also have additional need for legal services due to their unique health, income, and social status. Older people are often dependent upon services provided by large government bureaucracies using complex and often changing regulations, guidelines, and procedures. Affordable, competent legal assistance is critical to their ability to obtain basic necessities such as health care, in-home support services, protective services, or other benefits. Legal problems of elderly persons may also relate to discrimination in the workplace, a landlord-tenant controversy, or other disputes which may require judicial intervention.

AARP believes that legal services for older persons should be reauthorized as a priority service under the Older Americans Act. Because many AAAs provide little or no legal services to older persons, the law should be amended to require at least 6 percent of the funds appropriated under Title III (B) to planning and service areas be expended for each priority service. The establishment of at least 6 percent of Title III (B) money would restore legal services funding to its FY 1980 level. However, maintenance of effort language is necessary for programs currently spending more than 6 percent. It should be clear that 6 percent is not to be interpreted as a ceiling.

The Congress should also authorize a private right of action for procedural violations of the Act. This private right of action should extend to both service providers as well as program beneficiaries.

Under the current law, violations of the Act cannot be redressed in court since the courts have held that there is no implied cause of action or standing for affected parties. Without the ability to sue in court, an older person has no effective redress when, for example, an area agency illegally charges for meals under the Title III nutrition program, or fails to provide legal assistance within its planning and service area. Similarly, without standing in court, a legal services provider cannot sue a state for its failure to provide an administrative hearing in a situation where a local area agency had failed to provide legal assistance in its jurisdiction.

AARP further recommends authorization of a study to determine compliance with priority service requirements. The Secretary of the Department of Health and Human Services must enforce the Act with regard to priority services. In 1975, Congress authorized a study to examine the effectiveness of prioritizing services under the Act. The study revealed that prioritization did focus more money upon access, support, and legal services, but that legal services remained least favored among the three programs.

The Association supports Reauthorization and funding of Section 424 of the Act which authorizes national legal services support and demonstration projects operated by national non-profit legal assistance organizations. AARP further recommends a separate authorization of $1 million for the the work of national legal assistance organizations mentioned in 424 (a)(1) of the Act. Also the scope of 424 (a)(1) services should be expanded to serve legal assistance providers as well as state and area agencies.

National Legal Services support centers (such as the National Senior Citizens Law Center) provide training, support, and backup to lawyers who represent older clients. Assistance ranges from case consultation and legal advice to the development of training materials and programs for lawyers and paralegals.

Better Coordination of Services to Native Americans and Indians

AARP recommends that older Native Americans should also be served under Title III when such services are not duplicated under Title VI. It is vital for older Indians and other Native Americans to receive services under the Act through whatever mechanisms most efficiently meet their legitimate needs. Any view that Title VI, because it is targeted exclusively to Indians, should be the sole source of service to elderly Native Americans overlooks the needs of those off reservations who cannot be reached by tribal services. This proposal would also eliminate inequities resulting from overlap and administrative complications between Titles III and VI under the Act.

Strengthening the Ombudsman Program:

Ombudsmen play critical roles as consumer advocates for the nation's 1.5 million nursing home residents. Although there are ombudsman programs in every state and territory, their effectiveness varies widely. AARP believes that increased federal funding and stronger federal leadership is necessary to ensure the efficacy of this important program.

A number of changes are necessary to strengthen ombudsmen's direct roles in consumer protection. Not only state ombudsmen but their designees, such as local and volunteer ombudsmen, should be granted 24 hour access to nursing home and board and care facilities. With the approval of the resident or his/her representative, they would have the same access to residents and their records. Reprisals against residents or employees who file complaints should be strictly prohibited. Further, legal representation should be authorized for ombudsman programs and for ombudsmen who are the subject of legal action as a result of "good faith" effort to do their jobs. The federal government also needs to provide strong support for the establishment of ombudsman training and technical assistance programs at state and substate levels.

In addition to aiding individual residents, ombudsmen can be important conduits of information to regulatory agencies and to public officials. Mechanisms should be developed to ensure that state licensing and certification agencies (and where appropriate, PROs) consider data on problems of quality identified by ombudsmen. They would also share with ombudsmen such information.

The Older Americans Act makes ombudsmen responsible for advising public officials on the effects of laws and regulations on nursing home residents. This responsibility, however, can be interpreted as conflicting with OMB circular A-122 which prohibits federally funded programs from lobbying. Ombudsmen, including substate ombudsmen, should be exempted from the anti-lobbying provisions of this circular.

AARP opposes an extension of ombudsman authority into home health care services at this time. Ombudsmen have indicated that they do not have the resources to undertake an effective monitoring and advocacy role in this area. An extension of ombudsman authority into home care would jeopardize current work in nursing homes, as well as the expansion into board and care facilities that was authorized in 1981 but remains almost entirely unfulfilled.

Finally, a study on mechanisms to ensure the quality of care in nursing home, board and care, and home health settings should be undertaken. It should include, but not be limited to, representatives of consumers, providers, the Congress, HCFA, the Administration on Aging, and the AAAs. The study should include an analysis of quality control methods used in similar settings, i.e., those used with the mentally retarded/developmentally disabled.

Specialized Long Term Care Research, Education, and Training Centers

Our nation needs to build a much stronger base for research, education and training on community-based long-term care. As a step in that direction, AARP supports the authorization of funding under Title IV for up to 10 such specialized centers. The centers would be funded on a competitive basis for 5 year intervals. Centers would be evaluated yearly. Reapplication would be encouraged where evaluations show effective, innovative, and efficient operation. This would prevent costly and harmful service interruptions while assuring that effective performance is recognized. We envision at least the following criteria in the implementation process:

A. Applicants would include such entities as institutions of higher education, public agencies such as State Offices on Aging and AAA's, and non-profit organizations.

B. The centers would be focused topically, not by region, to support the development of comprehensive, coordinated community-based service systems and service delivery methods (including family support), to provide training and technical assistance in such methods, to support community education on long term care, to engage in research, education and training in close collaboration with community agencies including, but not limited to, agencies funded under the Older Americans Act. Center activity should focus on services designed to support alternatives to institutionalized living and the assessment of need, the development and coordination of plans of care, linkage among institutional (including hospital) and non-institutional providers, and family support.

C. Center activities should emphasize interdisciplinary and intergenerational approaches to service delivery and training and should include projects addressing the needs of special populations, including but not limited to the indigent, the oldest old, persons with Alzlheimer's disease and related disorders, the disabled persons, minorities, and rural elders.

Coordination of OAA with Programs for the Disabled and American Veterans

The elderly population is extremely diverse and has problems that are addressed by a broad array of federal and state agencies and programs. Frequently programs and agency administrators fail to maximize their effort on behalf of their client population due to lack of coordination. Two such areas of insufficient coordination on behalf of older persons by the aging network are veterans and the disabled. The Association supports coordination of services between programs under the Older Americans Act and programs serving veterans and disabled persons. AARP recomends that the Act be amended to reflect this clarification of the law.

Coordination should be encouraged between the aging network and the disability network generally, and should not be limited merely to coordination with the developmental disabilities network. The term "developmentally disabled" refers to mental and communications disorders whose onset occurs prior to adulthood. Therefore, those persons whose disabilities occur late in life would be excluded from the "developmentally disabled" population. We recommend, therefore, that language authorizing coordination of services should be broad enough to include all disabled persons, regardless of when their disabilities occurred.

In light of limited funds under the OAA, we recommend that coordination of services be permissive and not mandatory at this time. Since no one is sure exactly how many otherwise eligible disabled persons would require services under the OAA, we recommend that coordination be authorized initially on a discretionary basis. Similarly, more coordination of programs by AoA and those provided for veterans should be encouraged.

Concerns About Title V

Currently, sponsors under Title V (Community Services Employment for Older Americans) have a 13.5 percent administrative cap. This cap is unreasonably low given the high cost of placing senior workers in unsubsidized jobs. Among National Sponsors, unsubsidized placements is directly correlated with administrative cost. AARP believes that reinstating the 15 percent administrative cap would increase the number of elderly persons placed in unsubsidized employment. It would also help to ensure that national contractors expand job development activities. As a national sponsor, AARP has recently placed 45.5 percent of its enrollees in unsubsidized jobs. This was by far the best performance among national sponsors. However, the lower cap may jeopardize this placement record by forcing consolidation of projects and curtailment of job development acitvities. This could result in loss of employment opportunities for present and potential enrollees.

Another major concern of the Association about Title V is the inadequate level of service to Native Americans. Although Title V targets low income and minority populations, older Native Americans continue to be the least served population both in terms of numbers and level of need. The National Indian Council on Aging cites a poverty rate exceeding 60 percent for older Indians. The Administration on Aging and the Department of Labor should be directed to make a determination of how to best meet the employment and training needs of older Native Americans in a comprehensive strategy. Since certain minority groups are represented by at least one national sponsor under the Act, the study should give consideration to directing proportionate increases in Title V funding to the creation of a national sponsor for Native Americans.

1991 White House Conference on Aging

In order to focus attention on major issues of importance to older persons, the 1991 White House Conference on Aging should emphasize a unifying theme. This will enable policy makers, the aging community, and the public to better assess the present status of older Americans and to propose comprehensive solutions for the future. AARP endorses the theme "Maintaining Independence" for the 1991 Conference. It would address six areas: economic security; long term care; opportunities for a longer worklife; affordable health care; community building with intergenerational resources; and those left behind who are the most vulnerable populations.

Conclusion

As the aging population grows, greater demands are placed on the social service system. Therefore, an aging network that responds effectively to the needs of older persons is vital. Improved access to existing programs under Title III of the Act; expanded responsibilities of the state ombudsmen in protecting our older citizens in their living environments; improved legal services; better research, training, and demonstrations in the field of aging; and more fiscally responsible coordination and administration of programs serving the elderly should be the priorities of reauthorization.

AARP urges prompt reauthorization of the Older Americans Act. Our suggested changes to the Act and its administration, although requiring little statutory change, will help to greatly improve services for all older Americans. The elderly of our nation deserve our most careful attention to this important legislation.

Mr. KILDEE. Thank you very much.
Libby?

STATEMENT OF OLIVIA MAYNARD, DIRECTOR, MICHIGAN OFFICE OF SERVICES TO THE AGING

Ms. MAYNARD. Chairman Kildee and Congressman Sawyer, on behalf of the citizens of Michigan, I want to formally say how pleased we are that you have chosen to come to Michigan to hear testimony on the Older Americans Act, and just on a personal note to say that we in the Seventh Congressional District are most fortunate to have you as our Congress Member who speaks up and is committed to not only the elderly, but to all human services and to human beings.

As director of the Michigan Office of Services to the Aging, I want to just say before I get into my remarks that I do support the joint statement of NASU and NAAA on reauthorization of the Older Americans Act, and to say that the Michigan Commission on Aging has spoken in their legislative agenda in opposition to a change in the eligibility age, and also opposes any generic appropriation which, although not in the act, has been recommended by the President this year.

I want to concentrate my remarks on advocacy, the Administration on Aging's advocacy role and the state unit's advocacy role within the framework of the Older Americans Act.

There may be an improper perception of what advocacy is, that it is limited only to organizing demonstrations in public places and meetings. And certainly Senior Power Day where 6,000 older men and women from across the state gather with the legislature is an example of that kind of advocacy. But it is only one facet of a complex and coordinated activity, which we call advocacy.

Certainly you have heard from and you will hear from three very notable advocates, such as Clarice Jones—and I endorse heartily her statements on legal services—our ombudsman Hollis Turnham, and Keith McCall, who is the director of the Michigan Coalition on Aging Organizations.

But I want to talk about our office's advocacy role in a threefold fashion. Our first obligation is to serve. Our second is to collaborate and coordinate with other agencies and entities within a community and the state. And our third obligation is to empower.

First and foremost is our duty as an advocate to provide services. And it is critical that the federal government continue its commitment to serve. We certainly applaud you, Congressman Kildee, on your proposal for a new title III(d) for the frail elderly whose vulnerability and exposure to institutionalization do merit immediate attention.

We find it regrettable that the federal Administration and the Administration on Aging has not called for additional resources, and we are pleased that the reauthorization is going to, indeed, send the message to the President and his Administration that the promise to serve absent the commitment to expend is advocacy in retreat.

We have been looking for creative and innovative ways to address the needs that are increasingly unmet as a result of Reagan's budget years. Certainly two of these are transportation and housing, which although not directly within the framework of the Older Americans Act, we working with the legislature and other state agencies in the State of Michigan have tried to coordinate and collaborate services to meet those unmet needs. And this must be done at the federal level also.

We have looked to our advocacy in ways—looking at need surveys that show us what the needs are of our 1.6 million persons in the state 60 years and older. We do such things as convene the first governor's conference in 20 years so that we can encourage senior advocates from around the state to assemble and confer and learn from one another. And we train senior advocates. Our one week senior intern program in Lansing or the development of our manual on senior advocacy to which you contributed an article, and which we have copies for your committee to share with others, and which we have distributed around the state, are just some of the ways that advocacy is crucial to the independence and dignity of our elders in the state.

We believe that the Administration on Aging should also, and equally with energy, do this kind of advocacy and to dedicate sufficient resources and technical assistance to empower our seniors across this nation.

I thank you very much for your willingness to listen to all of us here in Michigan, and we are so pleased that you and Congressman Sawyer are with us today.

[The prepared statement of Olivia P. Maynard follows:]

James J. Blanchard, Governor
State of Michigan

Advocacy in the Older Americans Act

House Human Services Subcommittee
Hearing on Reauthorization

Testimony of
Olivia P. Maynard, Director
Michigan Office of Services to the Aging

April 11, 1987

Olivia P. Maynard, Director —— Stuart W. White, Legislative Director
Office of Services to the Aging, P.O. Box 30026, Lansing, MI 48909 517/373-8230

Congressman Kildee, on behalf of the citizens of Michigan who benefit from services authorized under the Older Americans Act, I want to thank you for seeking Michigan's input into the Congressional reauthorization of the Older Americans Act. The citizens of Michigan are indeed fortunate to be represented by a Congressman such as yourself who has demonstrated time and again a deep commitment to the concerns and needs of our elderly population.

As the Director of Michigan's Office of Services to the Aging, I want to preface my statement with the notation that I fully endorse the joint statement on reauthorization from the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Permit me also to add, that the Michigan Commision on Services to the Aging in it Legislative Agenda for 1987 opposes a change in the eligibility age for OAA services or funding formulas and also opposes a generic appropriation of any kind for OAA funds.

I have chosen to concentrate my statement today on advocacy, especially the Administration on Aging's advocacy role, within the framework of the Older Americans Act and the senior network.

There may be an improper perception that senior advocacy is limited to organized demonstrations in public places and meetings. Indeed, Michigan's Senior Power Day in which 6,000 senior leaders from around the state assemble in Lansing to present their elected officials with a platform for legislative and congressional change is one vital dimension of advocating for action that will enhance independence and therein preserve human dignity. But this public demonstration of senior power is merely one facet of a complex and coordinated activity that we call "advocacy".

You have heard from three notable senior advocates in Michigan.

Clarice Jones and her organization, the American Association of Retired Persons, has earned the respect of policymakers here and in Washington. Through careful deliberation and reasoned decision, this organization assesses the impact of legislative policy and appropriations debated in the legislature on its more than 800,000 members in this state. In addition to its legislative advocacy, AARP provides its membership with valuable services, such as affordable health insurance coverage, driver training instruction,. consumer protection, and a clearinghouse of information.

Hollis Turnham, the state's long term care ombudsman, has proven that the nursing home industry and the ombudsman program can collaborate on their common goals to minimize problems within the institutional setting and to enhance the quality of life for the residents of these institutiona. Advocacy aimed at problem solving which uplifts and enriches the social context be it a nursing home or a legislative body is an achievable goal. We have seen it work in Michigan.

Keith McCall, the executive director of the Michigan Coalition of Aging Organizations, reminds us that advocacy dedicated to a common interest transcending special interests can translate into a major force for change.

The Coalition has vigorously placed before the public and its government the importance of preserving and perfecting our health care delivery system to assure continued access to affordable, quality health care for our aging population. In placing this policy at the forefront of senior advocacy, the Coalition has evolved an understanding of the health care finance and delivery system that rivals the expertise of any organization. The Coalition is committed to letting the people who set policies and change laws know what the very clear and likely consequences of their actions will be. In this way, the Coalition is responding proactively to the issues affecting Michigan's aging population.

In another hearing, you heard about legal assistance advocacy which is one of three priority services upon which each area agency on aging must spend an adequate proportion of its alloted funds. Funding legal services for older persons is important for four reasons.

First, the reduction in funds for the federal Legal Services Corporation has shifted the growing demand for assistance to Title III legal services. Second, legal advocacy can often remove the obstacles to persons receiving benefits to which they are entitled such as Medicare, Medicaid, food stamps, fuel assistance. Third, public funding for legal services provides seed money for private programs such as Ford Motor Company's Senior Citizens Legal Project through which 50 of Ford's corporate attorneys serve older citizens' legal needs. Finally, legal services help build community awareness of issues relating to consumer fraud and protection, wills and estate planning, health care insurance and pension rights.

The Older Michiganians Act as well as the Older Americans Act directs the Office of Services to the Aging to act as a senior advocate. As the director of this Office, I view OSA's advocacy role in a threefold fashion.

First, our obligation is to serve.
Second, our obligation is to collaborate and coordinate.
Third, our obligation is to empower

As advocates our first and foremeost duty is to provide the services seniors need to retain their independence and dignity.

The Older Americans Act is the foundation upon which these services are developed. It is critical that the federal government continue its commitment to service and we applaud Congressman Kildee's proposal to include a new Title D for the frail elderly over 75 whose vulnerability and exposure to institutionalization merit immediate attention.

It is regretable that the federal administration and its Administration on Aging have not called for additional resources to serve the rapidly expanding older population of this country. Instead, the federal administration proposes to shift the duty to serve the growing number of older citizens of Michigan to the state and local government. In the absence of a willingness from the White House to request appropriations consistent with the increasing need for senior services, we would ask your committee to send the President and his administration the message that the promise to serve absent the commitment to expend is advocacy in retreat.

At the state level, the Office of Services to the Aging along with the legislature have been looking for creative and innovative ways to address the needs that are increasingly unmet as a result of the the Reagan budget years. We know from the 1985 Needs Survey of Michigan's 60 and over Population conducted in conjunction with the University of Michigan that transportation is the greatest unmet need for seniors in this state. Access to habitable housing follows closely behind. Older Americans Act dollars are limited and should not be expected to fill in gaps created by the massive shortage of Section 8 and Section 202 housing funds or the maldistribution of federal transportation funds to highway construction and repair.

Meeting the housing and transportation needs of Michigan's older population has become increasingly problematical. At the state level the legislature has directed OSA and other state agencies to collaborate and coordinate service delivery to respond to these unmet needs.

You will hear about a demand actuated transportation system in Detoit called Let's Go. This progam emerged in response to senior advocates organizing community support and interest that gained the attention of their state legislator. State Representative Ray Murphy, along with the Michigan Department of Transportation and the Office of Services to the Aging developed and implemented this unique project, which merits replication in other parts of the state.

Representative Murphy also initiated legislation that directed the Michigan State Housing Development Authority and the Office of Services to the Aging to institute shared housing demonstration projects around the state. Michigan's shared housing program has become the most successful of its kind in the country. In the first year, 200 persons shared housing and thereby reduced the government's need to construct 100 congregate housing units.

Both our shared housing program and Let's Go prove that interagency and intergovernmental collaboration and coordination can be productive. We would ask Congress in the Older Americans Act reauthorization to direct the Administration on Aging to pursue the same collaborative and coordinating role at the federal level. To achieve this outcome, it may be necessary to give the Administration on Aging greater autonomy within the Department of Health and Human Services. To this end, we would ask that the AOA Commissioner report directly to the director of HHS.

Advocacy should empower individuals to take responsibiliy for their own lives. In Michigan, OSA has implemented in the past two years three critical tools to assist in this empowerment.

First, the needs survey conducted by the University of Michigan provided the older population as well as government with a scientifically accurate picture of the over 1.4 million persons in this state 60 and older. This assessment allows policy decisions and advocacy goals to evolve from demonstrated needs rather than from theorectical propositions that presume need.

Second, last October, OSA convened the first Governor's Conference on Aging in 20 years. OSA has provided a number of conferences over the past two years which reviewed health care access issues, long term care insurance and finance issues. We will continue to encourage senior advocates from around the state to assemble, confer and learn from one another.

Third, we are constantly training senior advocates on what they can do to become more effective adovcates. We have provided trainings in fund raising techniques, marketing techniques, public speaking and public broadcasting, and even advocacy itself. We are indeed grateful to you, Congressman Kildee, for your contribution to our manual, Senior Advocacy in Action which we have distributed statewide and are sharing with you and your committee today. Borrowing from the model of the Washington Close Up program we have also implemented a govrnmental intern program for seniors in Michigan. Four years ago, the Office of Services to the Aging in cooperation with the Joint Legislative Committee on Aging initiated a Senior Intern program for the legislators serving on the joint committee. Through this program over 75 senior citizens in Michigan have spent a week in Lansing observing and participating in the legislative process. They have returned to their communities as trained advocates. Some have even been elected to public office following their training.

We would ask Congress to direct the Administration on Aging to dedicate sufficient resources and technical assistance to empower seniors to become more effective, more forceful and more visible advocates. Aging America is everybody's future. I see hope and promise in tomorrow. I see a caring, aging America preserving human dignity in our collective commitment to freedom. I see today the seeds of this tomorrow in your being here with us and your willingess to listen and act upon what you hear. Congressman Kildee, again, thank you for bringing Washington to us.

Mr. KILDEE. Thank you very much, Libby.

Keith McCall next.

STATEMENT OF KEITH McCALL, EXECUTIVE DIRECTOR, MICHIGAN COALITION ON AGING ORGANIZATIONS

Mr. McCALL. Thank you. My name is Keith McCall, and I am the executive director of the Michigan Coalition on Aging Organizations, and as the others, certainly pleased to be here.

This organization was created following the 1981 White House Conference on Aging by the Michigan delegates that came back from Washington. And it is made up of about 20—it's an organization of organizations. There are about 20 organizations, including the State chapters of groups like A.A.R.P., the National Council of Senior Citizens, the Senior Advocates Council of the State, UAW retirees, Teamsters and about 15 other groups.

We have studied at some length and we're committed to the principle that the federal government shall sponsor, fund and hold the next White House Conference on Aging in 1991 and shall initiate planning in 1987. It is our understanding that the basic way to assure that the above takes place is to make certain that the appropriate mandate be incorporated into the Older Americans Act, which is currently up for reauthorization through H.R. 1451.

It is our further understanding that this matter is under your purview inasmuch as you chair the subcommittee of the House Committee on Education and Labor.

The purpose of this testimony is to alert you to this need, and to seek your assistance in assuring that a mandate for holding of the 1991 White House Conference will be included in the reauthorization of the Older Americans Act. We understand that your role as chair of the subcommittee would include the responsibility to address this issue, and we assume that this matter would also include dealing with the adequate appropriation of funds for the event.

Although my personal experience has been limited to the 1981 events that were held in Michigan leading up to the final week in Washington, it is quite clear that to properly prepare for the national event, regional and State conferences must be held as they were in 1981 inasmuch as the issues ultimately addressed must reflect the actual concerns of elderly Americans. These regional and state conferences need some federal support so that a suitable focus on the issues can be realized.

From our survey of our 20 member organizations regarding a 1991 White House Conference, we have uncovered some concerns that more grassroots representatives should be involved as delegates with equal provision for meeting their expenses to attend the Washington meeting. We are continuing the preparation of a priority list of subject areas that we'd like to submit.

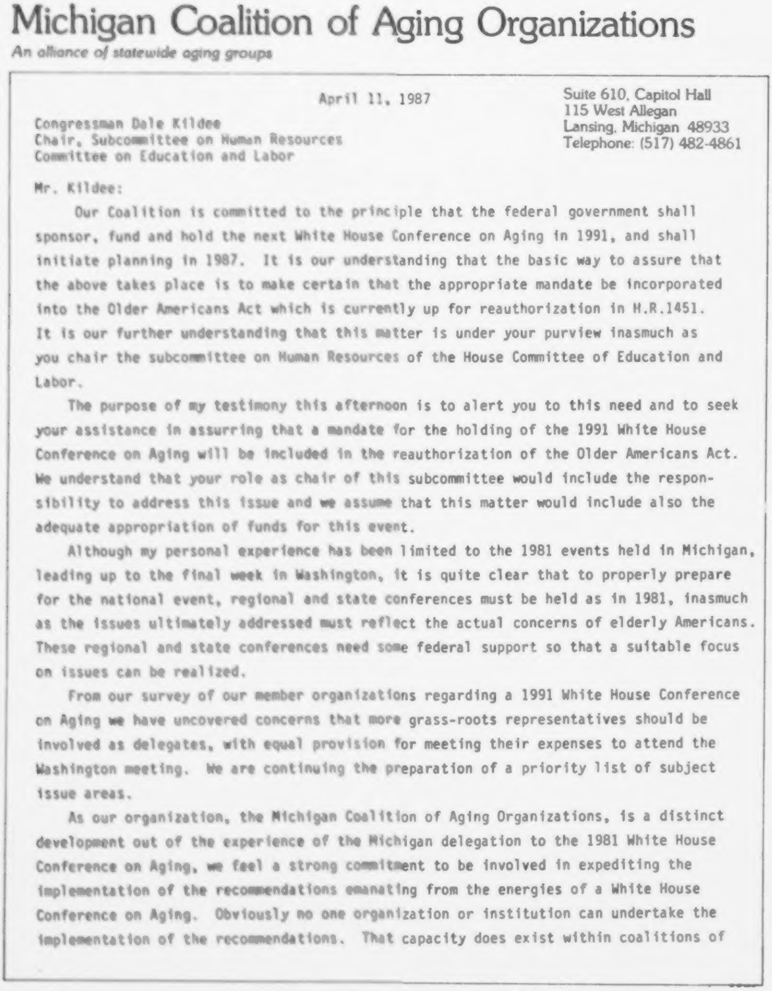
As our organization, the Michigan Coalition of Aging Organizations, is a distinct development out of the experience of the Michigan delegation to the 1981 conference, we feel a strong commitment to be involved in expediting the implementation of the recommendations emanating from the energies of a White House Conference. Obviously, no one organization or institution can undertake the implementation of the recommendations, but that capacity we feel does exist within coalitions of aging advocacy interests. It would seem prudent to us that planning responsibilities for a 1991 White House Conference should embrace also specific commitments for follow-up so that implementation will more likely occur.

As an aside, I might indicate that one of the three purposes of our coalition was, in fact, to assist in the implementation.

Perhaps a mandate for holding of a 1991 conference should address such a need from the inception of the planning for assurance that such a need is not overlooked.

We will certainly follow with interest the progress of your committee on this topic and would offer our assistance where you may feel that we could be of service. And we'd like to thank you for this opportunity to present this appeal to you.

[The prepared statement of Keith B. McCall follows:]



Michigan Coalition of Aging Organizations

An alliance of statewide aging groups

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April 11, 1987

Congressman Dale Kildee
Chair, Subcommittee on Human Resources
Committee on Education and Labor

Mr. Kildee:

Our Coalition is committed to the principle that the federal government shall sponsor, fund and hold the next White House Conference on Aging in 1991, and shall initiate planning in 1987. It is our understanding that the basic way to assure that the above takes place is to make certain that the appropriate mandate be incorporated into the Older Americans Act which is currently up for reauthorization in H.R.1451. It is our further understanding that this matter is under your purview inasmuch as you chair the subcommittee on Human Resources of the House Committee of Education and Labor.

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Although my personal experience has been limited to the 1981 events held in Michigan, leading up to the final week in Washington, it is quite clear that to properly prepare for the national event, regional and state conferences must be held as in 1981, inasmuch as the issues ultimately addressed must reflect the actual concerns of elderly Americans. These regional and state conferences need some federal support so that a suitable focus on issues can be realized.

From our survey of our member organizations regarding a 1991 White House Conference on Aging we have uncovered concerns that more grass-roots representatives should be involved as delegates, with equal provision for meeting their expenses to attend the Washington meeting. We are continuing the preparation of a priority list of subject issue areas.

As our organization, the Michigan Coalition of Aging Organizations, is a distinct development out of the experience of the Michigan delegation to the 1981 White House Conference on Aging, we feel a strong commitment to be involved in expediting the implementation of the recommendations emanating from the energies of a White House Conference on Aging. Obviously no one organization or institution can undertake the implementation of the recommendations. That capacity does exist within coalitions of aging advocacy interests. It would seem prudent to us that planning responsibilities for a 1991 White House Conference on Aging should embrace specific commitments for followup so that implementation will more likely occur. Perhaps the mandate for the holding of the 1991 Conference should address such a need from the inception of the planning, for assurance that such a need is not overlooked.

We will follow with interest the progress of work of your subcommittee on this topic and would offer our assistance where we may be felt to be of service.

Thank you for this opportunity to present our concerns.

Keith B. McCall, Director.

Mr. KILDEE. Thank you very much.

Ms. Turnham?

STATEMENT OF HOLLIS TURNHAM, STATE LONG-TERM CARE OMBUDSMAN

Ms. TURNHAM. Thank you, Congressman Kildee.

My name is Hollis Turnham, and as was introduced, I'm the state long-term care ombudsman, and I work for an agency called Citizens for Better Care.

As has been the history since its inception, the Citizens for Better Care was one of the seven demonstration projects established by President Nixon in 1972 to determine if a long-term care ombudsman project was a necessary component to serving older adults.

Michigan is one of the very unique states in the country that has continued to contract out the ombudsman grant outside of state government to Citizens for Better Care, which is an 18 year old membership group headquartered in Detroit.

My office in Lansing works very closely with Livy and her entire staff and the aging community to serve the 65,000 older adults who live in our long-term facilities.

I also serve as treasurer of the National Association of State Long-Term Care Ombudsman. And I think in your Washington hearing you heard from our president, Gerald DuSaun about our positions.

I would like to just highlight some specific Michigan concerns about the ombudsman in relationship to the Older Americans Act. First is that, particularly for ombudsman programs, but I think for all advocacy services within the Older Americans Act, circular 122-A of the Office of Management and Budget has got to be clearly eliminated from my list of things to worry about. Circular A-122 gets at the heart of what I see as my job description.

Let me give you two examples of where I think we may already be in trouble. Many people call us for assistance with long-term care insurance. It's a very complicated area. We set about with the financial assistance of the area agency that serves our Wayne County to try and figure out how to help people with that process. And we have produced what we think is the first consumers' guide in the country on what to look for when you're purchasing insurance either for nursing home care or for in-home services.

In it we talk about the difficulties that people face in that marketplace. One of those major difficulties is that there are no standardized definitions for what is skilled nursing care, what is custodial nursing care, what are in-home services. If some state legislator picked up this brochure and decided to introduce legislation in the State of Michigan defining what those policies have to say, I fear that we could be in trouble with OMB circular A-122 merely because we did our job. We educated elders and their families about what are the risks, what are the problems, what do you need to watch out for.

We have a similar concern with another issue that we have worked on for years, and that is the problem that Medicaid recipients have in gaining access to nursing home care. Again with the assistance of Area Agency 1B, which serves the six counties surrounding Wayne, in October of 1985 we conducted a day-long training in which 200 people attended—hospital discharge planners, legal services providers, legislative staff people, elder advocates of every type and variety imaginable in which we spent a whole day talking about the problems of Medicaid recipients in getting into a nursing home and staying in a nursing home.

As part of that continued support with the area agencies, we likewise produced another pamphlet, Medicaid for Nursing Home Care, Getting in and Staying in, again where we outlined the problems, difficulties, rights, where you get information. Just this past week Representative Perry Bullard of Ann Arbor introduced a package of bills that address many of the problems that are raised in this pamphlet.

Again, I consider this work, this work that we were called on by our clients to perform, is tainted by OMB circular A-122. It is time that advocates within the aging network not have to worry about their financial stability because they're doing what Congress asked them to do.

The second issue that I'd like to highlight is the need that doesn't exist here in Michigan, but that we hear exists in other states, and that is, that the ombudsman program needs to have the independence and integrity to insure that it's able to do its job effectively. In Michigan we don't have that concern. The state unit on aging is what is called a type 1 agency except for continual, perennial budgetary issues. Livy Maynard answers only to the governor. In other states the state office on aging is part of another state department, many times part of the same state department that regulates nursing homes or that finances Medicaid. And my counterparts in those states do not have the degree of independence or integrity to go forward with their jobs.

We do not advocate that everybody take on the Michigan model. The Michigan model has worked here because of our own unique history and because of the governmental structure here. But there has to be a mandate within the Older Americans Act that the ombudsman program, wherever it is located, funded, authorized, reports to, has to have the measure of independence both from regulatory concerns that are appropriate and provider concerns that are appropriate because the ombudsman all too frequently is the only person to speak solely for the residents. And that voice must be clear and it must be free of pressures to represent other concerns that can and are being represented by other people.

I would also like to thank you, Congressman Kildee, not only for coming here, but also from what I understand is the open and fair and thoughtful way in which you and the other members of your committee and your staff are approaching the reauthorization of the Older Americans Act. It is very much appreciated and thankfully noted.

[The prepared statement of Hollis Turnham follows. Additional material submitted by Ms. Turnham is in subcommittee files.]

Citizens for Better Care
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(517) 482-1297 (800) 292-7852

REAUTHORIZATION OF THE FEDERAL OLDER AMERICANS ACT

Testimony to the United States House
of Representatives

House Committee on Education and Labor
Subcommittee on Human Resources

April 11, 1987

by

Hollis Turnham
State Long-Term Care Ombudsman

Funded by the United Foundation of Metropolitan Detroit, the United Way of Pontiac North Oakland, the Michigan Office of Services to the Aging, Area Agencies on Aging IA, IB, II, VI and VIII, Kent County Social Services Board, City of Grand Rapids, membership dues and donations.

I am Hollis Turnham, Michigan's State Long-Term Care Ombudsman (SLTCOP) with Citizens for Better Care (CBC), an 18 year old non-profit consumer organization concerned about the quality of care in nursing homes and board and care facilities. CBC is funded through the Michigan Office of Services to the Aging (OSA) to administer the SLTCOP.

I am very pleased to submit this written testimony to the Subcommittee on Human Resources from the U.S. House Committee on Education and Labor with the views of the SLTCOP and CBC on the long-term care Ombudsman provisions of the federal Older Americans Act (OAA).

In Michigan, an ombudsman program has existed since 1972 when CBC received one of the seven national demonstration project grants. Under the 1975 Amendments to the OAA, CBC applied for and received funds from the OSA for the SLTCOP.

Thus, when the 1978 Amendments were passed, Michigan's OSA contracted with the existing CBC program to carry out the SLTCOP rather than establish a new in-house ombudsman program as was done in the majority of states. CBC has been awarded the MIchigan contract since that time. All but one, newly designated local Michigan Ombudsman projects have formal corporate affiliation with CBC.

The Michigan Ombudsman network has worked long and hard in service to the 65,000 elder residents of its 441 nursing homes, 125 homes for the aged, and its 4,000 licensed Adult Foster Care (AFC) homes. I have attached a copy of the Executive Summary of last year's Annual Report which shows a **36% increase** in Ombudsman work over the previous year.

While a number of issues relative to the Ombudsman program in the OAA have been raised by the National Association of State Long-Term Care Ombudsman Programs and others, the Michigan program would like to emphasize its two major concerns.

1. Clear exemption from the broad, tenuous definition of lobbying contained in OMB Circular A-122 must be provided.

2. Ombudsman programs must have sufficient independence from both "provider" and "regulatory" influences to effectively advocate the interests of long-term care residents.

OMB Circular A-122

For several years, Ombudsman programs have been

(Page two)

operating under the cloud of OMB Circular A-122 and its financial threat. The gag of silence that the Office of Management and Budget has attempted to place on advocacy agencies must be removed if Ombudsmen are to do their work. The potential for damage by the imposition of OMB Circular A-122 is immense. I would like to give two examples.

The heart and soul of Ombudsman work is complaint resolution and community education. We attempt to educate residents and consumers about the long-term care system so that the quality of care and life is high.

We are able to do that because of our clients. They tell us, maybe not in an articulate, regulatory fashion, the issues, problems, concerns, and questions they face on a daily basis. We work with those clients to find solutions and answers. Those answers are then made available to others. The most recent such issue we worked on is long-term care insurance.

Many people called us for advice about what policy to buy or what questions to ask. In response to those questions, Michigan Ombudsmen set about to find answers and provide guidance to its clients. With financial assistance from the Senior Alliance, the area agency on aging serving Wayne County, we produced the attached booklet, "A Consumers Guide to Long Term Care Insurance."

The Guide contains a lot of advice and presents the potential problems in searching for long term care insurance. It points out that there are no mandated common definitions of "skilled nursing care" or "custodial care" or "in-home services." Without such definitions, it is very difficult to comparison shop among different policies.

We are very proud of our Guide. We believe that it represents the best of what a good Ombudsman program is about--finding out answers to complicated issues, and making those answers available to the elder community for their use to prevent problems.

However, we could be penalized for our work if any legislator read the Guide and decided that Michigan needed to help consumers by mandating a common definition of "skilled nursing care" and other terms for all health policies. The Circular would argue that our work in educating the public is lobbying because a legislator gleaned a possible legislative solution from our community education materials and legislation was introduced.

(Page three)

We face exactly the same problem relative to the development of our brochure "Medicaid for Nursing Home Care: Getting In and Staying In." Since 1978, the thousands of people who yearly contact us for help in finding a nursing home placement have reported a myriad of problems related to their status as Medicaid recipients. Again, with the financial assistance of Area Agency on Aging 1B which serves the six counties surrounding Wayne and OSA, the Michigan Ombudsman network presented a full day training in October, 1985, on the problems of Medicaid recipients in accessing nursing home care. Some 200 hospital discharge planners, legal services providers, legislative staff members, senior citizens and other advocates for elders learned about the problems and solutions of getting nursing home care for Medicaid recipients. The training was repeated a year later in Muskegon and will be available in June in the Upper Peninsula, again with the financial assistance of the responsible area agency on aging.

In the last two weeks, legislation has been introduced which addresses several of the problems explained in the brochure and reported by the Michigan Ombudsman network for years. Again, we fear that every annual report prepared by the Michigan SLTCOP since 1978 which notes that Medicaid discrimination is the #1 problem will be viewed by OMB as "tainted lobbying." The Circular threatens all those educational presentations.

The OAA requires the SLCTOP to:

-receive and investigate complaints from and concerning the care elders receive in the state's nursing homes;

-monitor the development and implementation of laws affecting long term care residents; and

-provider information to the public about long term care residents and their problems.

We believe our work on long term care insurance and Medicaid discrimination is the mandate of an Ombudsman program. It is unfair to jeopardize an agency's financial well-being for caring out its mandated functions.

If the Circular is applicable to the Ombudsman services described here, there will be no Ombudsman services in the country worthy of the name. The OAA must clearly provide that Ombudsman services are not subject to the provisions of OMB Circular A122.

(Page four)

Independence of Ombudsman Programs

Although this issue is not a direct concern of the Michigan Ombudsman network, we would like to join other states Ombudsman programs in requesting that the OAA be amended to insure that sufficient independence from both governmental "regulatory" and "provider" concerns and influence is accorded Ombudsman programs. If such distance is not provided, we question the ability of the project to effectively advocate the interests of long term care residents.

Other state Ombudsman have looked upon the Michigan model--OSA and the AAAs contract with an outside advocacy agency such as CBC to provide Ombudsman services--with some measure of admiration and desire for imitation. Some view the Michigan model as the pinnacle of independence. This model has, I believe, worked very effectively in Michigan.

However, it is not necessary or appropriate to mandate its replication in any or every state. The pecularities of Michigan's governmental structure and history of long term care advocacy have created and fostered the Michigan model. That structure and history do not exist in any other state.

Instead, all other states can and should assure the same kind of services and effectiveness if the OAA mandates the same kind of independent and yet cooperative working relationships present in the Michigan Ombudsman network.

No matter where the state or local Ombudsman program is locally authorized, housed, funded, or supervised Ombudsman must the independence and resources to speak **for the residents.** While the interests, concerns, and abilities of regulatory agencies and providers should not and cannot be forgotten, there are many to represent their concerns. All too often, the Ombudsman is the **only** one able to speak for the residents. The Ombudsman must be free of even the appearance of a conflict of interest with regulatory and provider concerns in order to effectively represent long term care residents.

The AoA, through amendatory language to the OAA, must take seriously the mandate of an Ombudsman program dedicated to resident concerns.

CBC and I appreciate this opportunity to present these thoughts on the the reauthorization of the OAA.

EXECUTIVE SUMMARY

FY 1985-86 ANNUAL REPORT
of the
STATE LONG TERM CARE OMBUDSMAN PROJECT
of
CITIZENS FOR BETTER CARE
to the
MICHIGAN OFFICE OF SERVICES TO THE AGING

Submitted by:

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DESCRIPTION OF MICHIGAN'S OMBUDSMAN NETWORK

With amendments in 1975, the federal Older Americans Act (OAA) mandated state units on aging, such as the Michigan Office of Services to the Aging (OSA), to establish state long term care Ombudsman programs:

-to receive and investigate complaints from and concerning the care elders receive in the state's nursing homes;

-to monitor the development and implementation of laws affecting nursing home residents;

-to provide information to the public about long term care residents and their problems, and

-to support and encourage the development of local citizens groups in the work of the Ombudsman programs.

That 1975 mandate has remained largely unchanged but for the 1978 addition of Michigan's homes for the aged and adult foster care (AFC) homes as a kind of "long term care facility" under the responsibility of the state Ombudsman.

Only seven of the state's fourteen Area Agencies on Aging have local projects serving any portion of their service areas; two of those have no paid staff. Attached as Exhibit I is a list of the local projects, professional staff (FTE); number of volunteers, and the sponsoring organization. Attached as Exhibit II is a list of the number of nursing homes, the number of nursing home beds, and the number of square miles in the service area for each local Ombudsman project.

In over 1,000 visits to nursing homes, Ombudsman staff and volunteers talked with residents and their family and friends, home staff, and administration to resolve issues and participate in staff trainings, family and resident council meetings, and resident care conferences.

COMPLAINT RESOLUTION WORK

Viewed in total, the majority of local Ombudsman time and a substantial amount of state Ombudsman time is devoted to the resolution of the problems, issues, and concerns in the lives of nursing home residents.

During the reporting year, 954 individual cases representing 1773 individual issues were handled and closed by state and local Ombudsman projects. This represents **a thirty-six percent (36%)** increase over the last reporting year.

Attached Exhibits IV and V list the complaint category sections in order of frequency and the "Top Ten Individual Complaint" categories.

PUBLIC INFORMATION

During the reporting year, Ombudsman programs assisted over 3,700 people seeking information about nursing homes and other long term care services. This number of requests for service also represents a 36% increase over last year.

The Ombudsman projects also participated in 140 training/speaking engagements to over 4,600 people statewide.

MAJOR ISSUES OF CONCERN

Once again, the major issue of concern raised by current and prospective nursing home residents, their families and friends, other OAA funded providers, government officials, and hospital discharge workers is **access** to nursing home care for Medicaid recipients. Locally, the issue is referred to as "Medicaid discrimination," and exists at admission and the during the stay of residents.

The second major issue of concern identified by the Ombudsman network is the need for more nursing staff in nursing homes to carry out the work/services of the facility. More and more complaints are being voiced about the need for additional staff, care needs that are not being met because "we are down an aide," and employees leaving a facility in frustration over the "impossible demands" placed on them.

The Ombudsman project recommends legislative changes to address both issues.

EXHIBIT I Page 1
U.S. OMB #0980-0121
Expiration date: 10/31/86

State: Michigan; FY 1986

State Level Program	Amount of Funding - Source	Nature of Sponsoring Organization	Staff
Michigan Long-Term Care Ombudsman Project Citizens for Better Care 1627 E. Kalamazoo Lansing, MI 48912 (517) 482-1297 1(800) 292-7852	$ 1,000 Advocacy Assistance Grant 88,844 Title III-B allocation 8,000 State revenue $ 97,844 Total	CBC, Inc., a Michigan non-profit corporation 1553 N. Woodward Ave. Suite 525 Detroit, MI 48826 (313) 962-5968 A non-profit citizens advocacy organization	10 volunteers 2.5 Professional FTE .8 Clerical FTE
Local Programs			
Detroit/Wayne County CBC 1553 Woodward Ave. Suite 525 Detroit, MI 48826 (313) 962-5968	$ 50,901 - AAA 1-A Title III-B 23,590 - AAA 1-C Title III-B $ 74,491 Total	CBC, Inc., a Michigan non-profit corporation 1553 N. Woodward Ave. Suite 525 Detroit, MI 48826 (313) 962-5968	21 volunteers 2.2 Professional FTE .75 Clerical FTE
Oakland County Regional CBC 28600 W. Eleven Mile Road Farmington Hills, MI 48018 (313) 476-2040	$ 38,500 - AAA 1B Title III-B 8,200 - United Way $ 46,700 Total	CBC, Inc., a Michigan non-profit corporation 1553 N. Woodward Ave. Suite 525 Detroit, MI 48826 (313) 962-5968	8 volunteers 1.5 Professional FTE .5 Clerical FTE
Region 8 AAA Ombudsman Program CBC 215 Straight St., N.W. Grand Rapids, MI 49504 (616) 451-2302	$ 9,563 - AAA 8, Title III-B 4,000 - City of G.R. revenue 5,000 - Kent County revenue 1,990 - United Way of Kent Co. 5,495 - OAA Title V 2,482 - Dyer Ives Foundation $ 28,530 Total	CBC, Inc., a Michigan non-profit corporation 1553 N. Woodward Ave. Detroit, MI 48826 (313) 962-5968	13 volunteers 1.25 Professional FTE .5 Clerical FTE

EXHIBIT I Page 2

Local Programs (cont'd.)	Amount of Funding - Source	Nature of Sponsoring Organization	Staff
Region 6 Ombudsman CBC 1627 E. Kalamazoo Lansing, MI 48912 (517) 482-1297	$ 5,024 - AAA 6 Title III-B	CBC, Inc. a Michigan non-profit corporation 1553 N. Woodward Ave. Suite 525 Detroit, MI 48826 (313) 962-5968	2 volunteers .4 Professional FTE .1 Clerical FTE
Grand Traverse Ombudsman CBC - Grand Traverse Chapter 1125 W. Civic Center Dr. Traverse City, MI 49684 (616) 941-1399	$ 1,680 - Title V OAA	CBC, Inc. a Michigan non-profit corporation 1553 N. Woodward Ave. Suite 525 (313) 962-5968	6 volunteers .25 Clerical FTE
Marquette County Commission on Aging 184 U.S. 41 Hwy. Negaunee, MI 49866 (906) 475-4147	None	Marquette County Unit on Aging 184 U.S. 41 Hwy. Negaunee, MI 49866 (906) 475-4147	5 volunteers 0 FTE
	Total $254,269.00	65 volunteers 7.8 Professional FTE 2.9 Clerical FTE	

EXHIBIT II

SERVICE RESPONSIBILITIES FOR MICHIGAN LOCAL OMBUDSMEN

PROJECT	Number of Nursing Homes	Number of Nursing Home Beds	Square Miles	Number of Professional Staff
Regions 1A & 1C (Detroit & Wayne County)	94	12,145	600	2.2 FTE
Region 1B-Oakland Regional (Monroe, Livingston, Washtenaw, Oakland, Macomb, St. Clair)	78	10,181	3,920	1.5 FTE
Region 6 (Ingham, Eaton & Clinton)	15	1,754	1,702	.4 FTE
Region 8 (Kent, Allegan, Ionia, Montcalm, Mecosta, Osceola, Lake, Newaygo, Mason)	54	5,052	6,012	1.25 FTE
Region 10 (Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford)	14	1,408	4,717	0 FTE
Region 11 (Marquette County only)	3	319	600	0 FTE
Regions 2,3,4,5,7,9,11,14 (No local Ombudsman projects)	183	16,820	39,157	0 FTE
TOTALS	441 Nursing Homes	47,679 Beds	56,708 Square Miles	5.35 FTE

U.S. OMB #0980-0121
Expires 10/31/86

EXHIBIT III
Page 1

State: Michigan
Fiscal Year: 1985-1986

STATE LONG TERM CARE OMBUDSMAN REPORT

A. Statistics on Individual Complaints - Provide answers in the blank on the right.

1. How many individuals filed complaints with the Statewide Ombudsman Program during the 12 month reporting period? # 954

Optional

How many other individuals contacted the program for information and assistance only, not to file a complaint? # 3736

2. What was the total number of complaints closed during the 12 month reporting period? "Complaint" is defined as actual problem received by the Ombudsman Program (not by some other agency, such as the Health Dept.) and recorded in the Ombudsman complaint documentation system. (Complaint is distinguished from complainant in question #1 because one individual might report several problems or complaints, each of which would require separate classification in the State's list of types of complaints.) # 1773

3. What percent of the complaints received were:

Investigated by a representative of the Ombudsman Program? 65%

Referred to the Health Department for investigation? 31%

Referred to an agency or organization other than the Health Department for investigation? 4%

Total: 100% of complaints received

4. What percent of the total number of complaints investigated by the Ombudsman Program were:

Verified or partially verified? (Substantiated or partially substantiated through interviews, records, inspection, observation, etc.) 53%

EXHIBIT III

Page 2

Undetermined? (The investigation did not provide sufficient evidence to reliably determine the validity or invalidity of the complaint.) 35%

Not justified? (The complaint was shown through interviews, records inspection, observation, etc. to be invalid, or inaccurate.) 12%

Total 100% of complaints investigated by Ombudsman

5. What percent of the total number of complaints received were:

Resolved or partially resolved? (The problem reported was corrected or partially corrected to the satisfaction of the complainant and/or the Ombudsman, and a change has occurred.) 44%

Not resolved? (The problem identified by the investigation has not been corrected, and no change has occurred.) 4%

Explained? (The findings of the investigation did not indicate a need for change or warrant Ombudsman intervention. The complainant received an explanation.) 33%

Discontinued or withdrawn? (The case was discontinued at the option of the Ombudsman, or the complaint was withdrawn by the complainant or for other reason.) 18%

*Still active by the end of the reporting period?

Total: 100% of complaints received

6. What percent of the complaints received were primarily against, or primarily pertaining to:

Conditions or problems in skilled nursing facilities (SNFs)? 10.5%

Conditions or problems in intermediate care facilities (ICFs)? 18.4%

Conditions or problems in concurrent SNF/ICFs? 57%

EXHIBIT III

Page 3

Conditions or problems in non-nursing group living facilities which provide board and some degree of personal care? (Michigan's licensed homes for the aged and AFC homes.)	7.3%
The regulatory agency?	.11%
The reimbursement agency?	1.65%
Guardians or the need for guardians?	.61%
Family members?	.20%
Other - specify:	4.23%

Hospitals - the overwhelming majority
Senior housing
Home health agencies
Senior citizens center
Attorney
Veterans facility
HMO
Dentist

Total: 100% of complaints received

7. If your state uses the categories on the following two pages for recording types of complaints, provide totals for each category and sub-category for the 12 month period. If data is available, provide separate totals for nursing homes and board and care homes. (The categories were recommended in Chapter XIX of the Ombudsman Technical Assistance Manual, issued in AoA-IM-82-2, October 15, 1981.)

   If your State does not use these categories, identify the five specific sub-categories on the list which you believe were most frequently reported to your Ombudsman Program during the reporting period. If data is available, provide separate lists for nursing homes and board and care homes.

*Our system only reports cases/complaints at closing. Cannot calculate number of complaints still open.

COMPLAINT CATEGORIES

RESIDENT CARE - Total 694

A-1 [illegible]	A-1 121	A-17 Doctor not called	A-17 14
A-2 [illegible]	A-2 61	A-18 Staff attitudes	A-18 23
A-3 [illegible]	A-3 25	A-19 Staff poorly trained	A-19 10
A-4 [illegible]	A-4 8	A-20 Poor quality of	
A-5 [illegible]	A-5 20	A-20 [illegible]	A-20 37
A-6 [illegible]	A-6 28	A-21 [illegible]	A-21 14
A-7 [illegible]	A-7 34	A-22 [illegible]	A-22 1
A-8 [illegible]	A-8 26	A-23 [illegible]	A-23 9
A-9 [illegible]	A-9 7	A-24 [illegible]	A-24 7
A-10 [illegible]	A-10 16	A-25 [illegible]	A-25 5
A-11 [illegible]	A-11 37	A-26 Changes to care plan	A-26 15
A-12 [illegible]	A-12 54	A-27 Lack of/poor medical equipment (wheelchairs, walkers, [illegible], etc.)	A-27 16
A-13 [illegible]	A-13 2	A-28 [illegible] in poor condition	A-28 6
A-14 [illegible]	A-14 19	A-29 Other (specify)	A-29 18
A-15 [illegible]	A-15 38		
A-16 [illegible]	A-16 23		

PHYSICIAN SERVICES - Total 40

B-1 Schedule of visits	B-1 4	B-5 Not responsive in emergency	B-5 3
B-2 [illegible]	B-2 0	B-6 Does not take Medicare/Medicaid	B-6 0
B-3 Uncooperative, unresponsive	B-3 17	B-7 Other (specify)	B-7 0
B-4 Diagnosis, treatment	B-4 16		

MEDICATIONS - Total 77

C-1 Not given according to orders	C-1 37	C-4 Shortage	C-4 1
C-2 Administered by inappropriate staff	C-2 3	C-5 Given against resident's will	C-5 2
C-3 Over-sedation	C-3 21	C-6 Other (specify)	C-6 13

D. FINANCIAL - Total 134

D-1 Billing/accounting wrong, denied	D-1 17	D-6 Questionable charges	D-6 47
D-2 Access to own money denied	D-2 6	D-7 Misuse of personal funds by facility	D-7 13
D-3 Not informed of charges	D-3 2	D-8 Deposits, other money not returned	D-8 26
D-4 Charged for services not rendered	D-4 4	D-9 Other (specify)	D-9 15
D-5 Charges not approved in advance	D-5 4		

E. FOOD/NUTRITION - Total 166

E-1	Cold	E-1 12
E-2	Unappetizing, little variety	E-2 22
E-3	Choices	E-3 3
E-4	Snacks	E-4 3
E-5	Not assisted in eating	E-5 30
E-6	Special diet not followed	E-6 14
E-7	Preferences not considered	E-7 8
E-8	No water available	E-8 13
E-9	Nutritionally poor	E-9 10
E-10	Religious preferences not followed	E-10 0
E-11	Insufficient amount	E-11 11
E-12	Unsanitary	E-12 5
E-13	Time span	E-13 4
E-14	Lack of utensils	E-14 1
E-15	Other (specify)	E-15 11

F. ADMINISTRATIVE - Total 258

F-1	Understaffing	F-1 84
F-2	Admissions procedures	F-2 19
F-3	Admission refused due to medicaid status	F-3 6
F-4	Discharge plans	F-4 12
F-5	Improper placement	F-5 7
F-6	Transfer due to Medicaid status	F-6 6
F-7	Other improper transfer	F-7 30
F-8	Bed not held	F-8 16
F-9	Room charge adjustments	F-9 21
F-10	Roommate conflicts	F-10 8
F-11	Improper use of staff	F-11 3
F-12	Medical transportation	F-12 5
F-13	Language barrier (including sign language)	F-13 1
F-14	Laundry procedures	F-14 2
F-15	Other (specify)	F-15 20
F-16	Illegal private-pay contract	F-16 10
F-17	Denial of access to facility	F-17 7

G. RESIDENT RIGHTS - Total 117

G-1	Restrictions on right to complain	G-1 2
G-2	No grievance procedures	G-2 0
G-3	Religious rights restricted	G-3 2
G-4	Civil liberties (e.g. vote) restricted	G-4 0
G-5	Social/community activities restricted	G-5 2
G-6	Medicaid discrimination other than admission or transfer	G-6 0
G-7	Religious discrimination	G-7 0
G-8	Race discrimination	G-8 0
G-9	Sex discrimination	G-9 0
G-10	Not informed of condition	G-10 6
G-11	Not informed of rights, policies	G-11 2
G-12	Confidentiality of records	G-12 1
G-13	Access to own records	G-13 5
G-14	Denied rights	G-14 5
G-15	Visiting hours	G-15 2
G-16	Mail opened/not given	G-16 2
G-17	No phone privacy	G-17 0
G-18	Not treated with dignity/respect	G-18 6
G-19	Physical abuse by other resident	G-19 2
G-20	Verbal abuse by other resident	G-20 1
G-21	Use of possessions restricted	G-21 3
G-22	Kept in facility against will	G-22 16
G-23	Personal items lost, stolen or used by others	G-23 46
G-24	Violation of privacy	G-24 6
G-25	Married--share room	G-25 1
G-26	Other (specify)	G-26 7

H. BUILDING, SANITATION, LAUNDRY - 158

H-1	Cleanliness	H-1 28
H-2	Safety factors (exits, fire, railings, etc)	H-2 12
H-3	Offensive odors	H-3 26
H-4	Appearance .	H-4 2
H-5	Pests	H-5 25
H-6	Bathroom	H-6 3
H-7	Linens	H-7 11
H-8	Handicap accessibility	H-8 1
H-9	Bed, bedside equipment	H-9 7
H-10	Storage space (amount, security of)	H-10 0
H-11	Supplies	H-11 5
H-12	Heating	H-12 14
H-13	Cooling, ventilation	H-13 6
H-14	Lighting	H-14 1
H-15	Water temperature	H-15 5
H-16	Other (specify)	H-16 12

NOT AGAINST FACILITY - 150

J-1	Financial (bad debts, [illegible]) not by facility	J-1 7
J-2	Medicaid not providing services	J-2 6
J-3	Medicaid reclassification	J-3 8
J-4	Other Medicaid problem except discrimination	J-4 13
J-5	SSI, Social Security	J-5 2
J-6	Medicare	J-6 19
J-7	Insurance	J-7 2
J-8	Guardianship, Conservatorship, power of attorney	J-8 19
J-9	Family problems	J-9 11
J-10	Wills	J-10 1
J-11	Outside social services agency	J-11 8
J-12	Needs less restrictive placement	J-12 2
J-13	Medicare DRGs/pressure for early release	J-13 34
J-14	DSS not paying for hospital leave days	J-14 8
J-15	Hospital complaints	J-15 7
J-16	Other	3

EXHIBIT IV

COMPLAINT CATEGORIES*

	Number	% Of Total
1. Resident Care (Group A)	694	39%
2. Administrative (Group F)	258	14.5%
3. Building, Sanitation, Laundry (Group H)	158	8.9%
4. Not Against the Facility (Group J)	150	8.5%
5. Food/Nutrition (Group E)	146	8.1%
6. Financial (Group D)	134	7.6%
7. Resident Rights (Group G)	117	6.6%
8. Medications (Group C)	77	4.3%
9. Physician Services (Group B)	40	2.4%
Total	1773	100%

*The attached listing of complaint categories (Exhibit III) should be reviewed to fully understand the significance of the hierarchy.

EXHIBIT V

TOP 10 COMPLAINTS

		#	% Of Category	% Of Total
1.	Inadequate hygiene care (Resident Care, Group A)	121	17%	7%
2.	Understaffing (Administrative, Group F)	84	33%	4.7%
3.	Bedsores (Resident Care, Group A)	61	9%	3.4%
4.	Physical Abuse (Resident Care, Group A)	54	7.7%	3.0%
5.	Questionable charges (Financial, Group D)	47	35%	2.6%
6.	Personal items lost, stolen, or used by others (Resident Rights, Group G)	46	19%	2.5%
7.	Neglect (Resident Care, Group A)	38	5.3%	2.09%
8-10.	Lack of restorative nursing (Resident Care, Group A)	37	5.3%	2.09%
	Resident falling (Resident Care, Group A)	37	5.3%	2.09%
	Meds not given according to orders (Medications, Group C)	37	48%	2.09%
	Totals	562		31.66%

Mr. **Kildee**. Thank you very much.

I have some questions. I am going to try, Tom, to keep myself under the five minute rule. We have a five minute rule in Congress, but very often some members take a 45 minute rule before they turn to the other members. So, kick me if I go beyond my five minutes, Tom.

Let me ask Libby specifically, but maybe all of you would join in. One of the things that I am really pushing hard in this bill is my $25 million extra authorization for the frail elderly. I keep telling people—and I believe it—that not only is that $25 million for frail elderly care morally right, because I think it respects a person's dignity when they passionately want to stay in their home, but I also believe that it's a fiscally prudent way to go, and that we can actually stretch the dollars we have for these programs by helping them stay in their home and giving them a modicum of the services.

Would you care to comment, Libby?

Ms. **Maynard**. My statement would be that I would agree with you that it is both a humane and a fiscally wise way to provide services for those who are, indeed, frail. And we'd be happy to send you some information certainly.

When the person speaks on case management, which is a more intense kind of intervention and not just the regular services, we will take note of the fact that we have been doing some research here in this state, indeed, to show that it makes a difference whether someone stays in their own home or goes into the hospital on emergency care or some kind of other institutional care. So, there is a humane reason, and we believe a fiscal reason, that people indeed should remain in their home as long as they can indeed stay there.

And that's why we were so pleased that you had seen that need, that special need, for the particular frail elderly. It really begins at about age 75 and intensifies at age 85. And look to a way to bring in a coordinated fashion more in-home services where there is a gap and where there is a need.

Mr. **McCall**. We have a good term for this that you might want to consider. It is called "elder aid". And the aid originally originated as an acronym for assurances for independence and dignity. But now it is down to "aid" because it has been manifested in a number of the very things you are talking about, services to provide the maximum opportunity to stay in your own home, which in the long run should be better for the person and probably a cheaper answer to society.

Mr. **Kildee**. Yes, Clarice.

Ms. **Jones**. I am very happy to hear this because it has been a hobby of mine ever since I started fussing around with programs that we develop the—keep them in their own home. I say keep us in our own homes because I'm one of them. And I feel very strongly that this will be both fiscally and humanely the better way to go.

I think it is also important that you are looking for more money because of the poverty status of the women in their 80s. There are—I think it is somewhere around 50 percent of single, elderly white women who are in poverty, and about 56 percent if you hit minority groups or blacks that are in poverty. And I think that is a terrible statement to be able to make in the United States.

Mr. **Kildee**. Hollis?

Ms. **Turnham**. Congressman Kildee, I would join in and say that I would agree with you. When I talked to people who speak with legislators about the same issue that you've talked about, they tell me that the legislative concern is that if you provide too many services to people, that families will back off on their commitments, that in some way the term is used that folks will be "dumped" into the system.

I would say, as both a personal and professional opinion after talking to thousands of family care givers, that legislators need to simply put that aside. That is not what is going to happen in this country. The machinations and gyrations and work that families do to care for their elders is not going to be bought off with making sure that respite care is available, making sure that adult day care is available. And I would again be more than willing to point to staff some of the recent surveys about family care giving that have recently come out. There are even some older ones. I remember one in particular from the Health Care Financing Administration that is a couple of years old where family care givers talk about they need services. They need some support. They need somebody just to help them along, not to take over the total burden, but to just bring some relief, some recognition and some time to themselves.

And I would agree that it is important that we move now because not only of the changing demographics of the elderly society, but also the changing demographics of my generation. The number of women who are not married and who do not have children represent a huge potential for institutionalization. The overwhelming majority of people in nursing homes are women who never married, or who are widowed, or who never had children, or who have outlived their children. We have got to refocus and rethink how we deliver care to my generation that is coming along.

Mr. **Kildee**. The respite care, which you have mentioned, is allowed under this bill that we're dealing with here because we feel that is a very important thing.

When you get into the frail elderly, one case I know of comes to mind. A woman is 87 years old, and her daughters are not very young. As a matter of fact, they could join the A.A.R.P. So, very often there are two generations of older people, and the younger of the generations is often unable to give the necessary assistance, because they are not very robust themselves. Very often that is forgotten. As health care increases longevity, that problem will increase also.

I will defer to you now, Congressman, and then I'll probably come back.

Mr. **Sawyer**. Thank you, Mr. Chairman.

Anyone feel free to respond to this but Ms. Turnham in particular. It has been suggested to this subcommittee that language may be necessary to specify the kind of access to facilities and records that may be necessary in the execution of responsibility as an ombudsman. Could you comment on the need for that sort of thing in

Michigan or from the kind of experience that you've had representing ombudsman nationally?

Ms. **Turnham**. Access is a critical issue, Congressman Sawyer. For many advocacy projects, particularly concerning nursing home care, it is one that has been going on for years, and it has a lot of history to it. Ten years ago ombudsman were regularly arrested for trespass for going into nursing homes. And as recently as July of 1976, we were similarly threatened with a trespass arrest for a home in metropolitan Detroit.

It is the essence of the ombudsman work. If you, as an ombudsman, do not have the authority to enter a long-term care facility as a matter of right, your ability to represent, to talk with, to find out what is going on in the facilities is minimal. In Michigan we have struggled with the problem for a long time, and I hope that the problem will be solved on Senior Power day when we hope that the governor will be signing our own state ombudsman legislation which broadens the access that we currently have to all the facilities mandated under the Older Americans Act.

Access to records is a different matter. I think the testimony of national association was when you look at it nationally, I think the consensus that you can reach from most ombudsmen is that most ombudsmen prefer not to have automatic access to records, that they prefer that the access to records be with either the permission of the resident or the resident's guardian. There are some ombudsmen programs across the country which have become more of a regulatory function and have access much as a state licensing office or the state welfare department. It is the philosophy of the agency that I serve. It is the philosophy carried forward in the state legislation that we have here in Michigan that we do not have access to records but for the permission of the resident and/or their guardian.

And I think that the Older Americans Act should carry forward that. It should encourage ombudsmen to make sure that the processes are available that homes recognize, that residents and their guardians have access to records so that that access can then be passed on to their authorized representatives, and that that's what needs to be made in there, that the residents have a right to look at their records, and that that right is transferrable to anyone they want, be it an ombudsman, a legal services attorney, a care manager, or whoever.

Mr. **Sawyer**. So, you wouldn't see any threshold for an ombudsman to require records other than that which came with the authority of the individual or the guardian.

Ms. **Turnham**. Of the resident, yes. Yes.

Ms. **Maynard**. I would concur with our state ombudsman and just simply add that the key role that an ombudsman plays, the ability to serve in an advocacy role and not a regulatory role, and if that is lost, then the positive impact of the ombudsman program could, indeed, be lost.

Ms. **Turnham**. That is our position. Other ombudsman programs I know have taken different positions. The New Jersey ombudsman model is a very different model, and I think they come as close to being a regulatory agency as someone else. But that is not under authority of the Older Americans Act. That's their own state legislation and power that they go through.

I know that your own—the state ombudsman in Ohio also has a very different function. The Ohio state ombudsman is the person that begins the process for civil fines. That is a system that I understand developed because of the peculiar histories of the regulatory system within Ohio. And I don't think that the Older Americans Act should prohibit Ohio from developing that sort of regulatory system. That is one that they think is working.

But in terms of access to records, I don't think that the Older Americans Act should mandate that every single ombudsman across the country have the power or responsibilities of either the Ohio State ombudsman or the New Jersey ombudsman.

Mr. SAWYER. But you would draw that distinction between facilities then and records.

Ms. TURNHAM. Yes. Facilities you must have access. What we're going for here in Michigan is 8 to 8 for staff. The volunteers will have access for nursing homes during regular posted visiting hours, which also must be 8 hours a day. And then for board and care facilities, we're setting it up 11 to 7. Eventually those hours, particularly for board and care facilities, may be expanded, but this is the first time we have ever had access to them.

We want to start with something that we thought was both manageable and, frankly, that we could actually pull off. With a professional staff of 10 ombudsmen statewide, I don't want people to be under the misconception that we are going to be in those 4,000 licensed adult foster care homes. We are just not going to be able to do that.

I hope that answers you.

Mr. SAWYER. It is an enormous help.

Can I ask one more question?

Mr. KILDEE. Sure.

Mr. SAWYER. It is similar in character, and goes right to the heart of the kind of thing that we are asked to do, so I want to ask your advice on it. If we're going to draw a similar kind of line between those activities that are appropriate and allowable kinds of advocacy and those that others might want to cordon off, where would you suggest that we draw that line?

Ms. TURNHAM. Between what and what, sir?

Mr. SAWYER. Appropriate kinds of advocacy and those that others might call inappropriate.

Ms. TURNHAM. I think clearly participating in any partisan activities. I think any sort of political endorsements of parties, candidates, those kinds of things. I think clearly if my board takes the position on a bill and spends money, contacts legislators on its own time, sends letters to legislators, that that must and would and is presently being counted toward lobbying. I think we frankly ought to look to—I am a registered agent in Michigan. We do have a lobbying statute. We report under that statute. But it doesn't go to the depth that every time I put out a brochure, I have to list it as lobbying activities. I think we need to return to and look at the traditional educational reporting.

I think we also have to understand that under the ombudsman legislation, we are supposed to look at how federal, state policies, rules, laws and regulations are operating. And I think as an ombudsman, I ought to be able to, when invited and particularly when asked, in my annual report or when next week I go before the Republican House Long-Term Care Task Force to tell them these are the issues as I see it, and here are a range of solutions, or here is something that has worked in another state and has not worked in a state.

I would also note—well, I think that that's where the lines should be drawn of the partisan activities, the ones before OMB circular A-122 existed. We worked well within those. We abided by those. We reported our lobbying activities as such, and did not report what I consider to be the advocacy mandated by the Older Americans Act.

Mr. **Kildee**. Would the gentleman yield?

Mr. **Sawyer**. Sure.

Mr. **Kildee**. On that point, it just occurred to me. I am not an advocate of the Hatch Act, but at least it is clearer than the confusion that has been created by the——

Ms. **Turnham**. Exactly.

Mr. **Kildee**. Circular A-122, combined with dropping the old regulations. You are out there in no man's land right now. You do not know what you can do.

Ms. **Turnham**. Exactly. Congressman Kildee, when I read that circular, I thought I can't even put out a newsletter.

Ms. **Maynard**. Congressman Kildee, we are the state unit. We are charged to be an advocate. So, we are protected. But our advocacy is of no use unless all those persons such as the Keith McCall and the Clarice Jones around the state and the Hollis Turnhams around the state can on a grassroots basis educate and encourage men and women to educate themselves to speak out on issues, to fight for legislation. If you are handicapped or so frightened by what is or is not said that you become inarticulate, then the heart of the Older Americans Act has gone even if we are as an agency protected.

Mr. **Sawyer**. You mean, you think you ought to be able to have First Amendment rights like other people?

Ms. **Maynard**. Yes. [Laughter.]

Mr. **Sawyer**. Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you.

You mentioned that you were almost arrested or could almost be arrested entering some of the homes. Several years ago, I think it was Joe Benavidez put me up to this, I went down and visited some migrant labor camps and almost got arrested there. I recall talking at one point with one of the owner's wives. She was very upset that I had come to visit the homes in which the migrant workers were living. I was trying to be very calm, and I stayed calm. I was very nicely talking about human dignity. Finally she said, you know, the trouble is there are too many do-gooders coming in. [Laughter.]

And I said very calmly it was probably better than being a dobadder. [Laughter.]

She didn't like that either.

But I think access is very important and I think we ought to address ourselves to make sure you have adequate access in those areas where you can really help the people.

I have no further questions. Tom?

Ms. MAYNARD. Congressman Kildee, my staff just handed me a note to be sure to mention that IRS has also proposed some rules against lobbying, which we certainly sent in our letter to protest against them. Those are even more insidious.

Mr. KILDEE. 501, yes.

Send us mail on that, too, would you?

Ms. MAYNARD. Well, we continue to even though the review period is completed.

Mr. SAWYER. Send us mail even though that in itself may be a violation. [Laughter.]

Mr. KILDEE. At the risk of being audited, I would say that probably the harshest branch of government is the IRS.

I thank you very much. I really appreciate your testimony.

Our next panel consists of Joanne Hartranft, the Mayor's Office on Aging and Handicapped; Suzanne Zerwick, Director of Lapeer County Commission on Aging; Valaria Conerly, Executive Director of the Valley Area Agency on Aging; and Charlotte Williams, Member of the Michigan Commission on Aging. I welcome all of you, my friends, to this panel here. I have known all of you for quite some time.

Joanne, I guess we call you first.

STATEMENT OF JOANNE HARTRANFT, MAYOR'S OFFICE ON AGING AND HANDICAPPED

Ms. HARTRANFT. I want to thank you, Congressman Kildee, for making it possible for us to testify today, and welcome Congressman Sawyer to the City of Flint on behalf of Mayor Sharp.

My name is Joanne Hartranft, and I am the Director of the Mayor's Office on Aging and Handicapped for the City of Flint. I want to thank you for the opportunity to speak with you today concerning the importance of the reauthorization of the Older Americans Act.

Through the availability of funds by this act, critical services are available to citizens age 60 and older within our city. The city is fortunate to have a wide range of programs for older people that are administrated through the Office on Aging and Handicapped and the Department of Parks and Recreation.

The majority of funds to operate these programs are currently appropriated through the City of Flint's general fund. As tax revenues continue to decline and the older population increases, we are challenged to seek other avenues of funding to maintain critical services that will guarantee a desirable quality of life for our older citizens. It is projected that all City of Flint departments, with the exception of police and fire, will experience a decrease in their operational budgets this year by approximately 15 percent.

Funds made available through the state Office on Aging and the Valley Area Agency on Aging have made it possible for us to improve the quality of services at our community centers. Those services include senior citizen congregate meals. Over the course of one year, the Flint Department of Parks and Recreation, in conjunction with the Genesee County Community Action Agency's Senior Food Program, has provided over 60,000 meals to senior citizens attending the following community centers: Brennan, Burstyn Field House, Haskell Community Center, Hasellbrane Park Senior Community Center, and McKinley Community Center.

Two, senior equipment and unmet needs. Through various grants from the state Office on Aging to the Flint Department of Parks and Recreation, we have secured a total of $26,000 of equipment for five of our six senior citizen centers over the past two years. The type of equipment varies from tables and chairs to kitchen equipment, coat racks and copy machines.

Senior center staffing. Over the past four years, the Department of Parks and Recreation has secured over $45,000 in grants from the Valley Area Agency on Aging to provide staff support at City of Flint senior centers. For example, Haskell Community Center is now recognized throughout the community for the excellent therapeutic recreation program available to people who are older and are recovering from catastrophic illnesses.

We are also fortunate to be able to provide intervention in suspected cases of elder abuse through counseling and services provided by a trained staff member at Hasselbrane Center.

Although there are many older people in the City of Flint who enjoy good health and adequate income, the number of low income, frail elderly is increasing. This segment of the population makes up that group of people who demand the most attention from local social service agencies. Through the Older Americans Act, critical nutrition, personal care and homemaker services are available.

Although we have an excellent adult day care center in Flint, a very limited amount of respite care services is available. I take this opportunity today to urge you to recognize the critical need to seek further funding for long-term and expanded respite care. Funds are needed to assist families who are caring for a frail spouse or parent at home. Institutionalization too often takes place when an older spouse is physically and emotionally exhausted due to the 24 hour demand of caring for someone with Alzheimer's disease or a similar disorder. For many of these people, once placement is made in an adult foster care home or a nursing home, the financial drain continues due to the fact that Medicare currently does not pay for extended basic or respite care.

In conclusion, I join my colleagues in urging the Congress to recognize the importance of reauthorizing the Older Americans Act and expanding services to provide respite care. The Older Americans Act is a base of assurance that all citizens regardless of income should feel confident that growing older does not mean growing needy.

Thank you.

[The prepared statement of Joanne Hartranft follows:]

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MAYOR'S OFFICE ON AGING AND HANDICAPPED

James A. Sharp, Jr.
MAYOR

Joanne M. Hartranft
DIRECTOR

MEMORANDUM

TO: Congressman Dale Kildee, Chairperson
House Education and Labor Subcommittee on Human Resources

FROM: Joanne Hartranft, Director
Mayor's Office on Aging and Handicapped

RE: Reauthorization of the Older Americans Act

My name is Joanne Hartranft and I am the Director of the Mayor's Office on Aging and Handicapped for the City of Flint. I want to thank you for the opportunity to speak with you today concerning the importance of the reauthorization of the Older Americans Act. Through the availability of funds by this Act, critical services are available to citizens aged sixty and older in the city of Flint. The city is fortunate to have a wide range of programs for older people that are administered through the Office on Aging and Handicapped and the Department of Parks and Recreation. The majority of funds to operate these programs are currently appropriated through the city of Flint's general fund. As tax revenues continue to decline and the older population increases, we are challenged to seek other avenues of funding to maintain critical services that will guarantee a desirable quality of life for our older citizens. It is projected that all city of Flint departments (with the exception of police and fire) will experience a decrease in their operational budgets of approximately 15%. Funds made available through the State Office on Services to the Aging and the Valley Area Agency on

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"An Equal Opportunity Employer"

Aging have made it possible for us to improve the quality of services at our community centers. These services include:

1. Senior Citizen Congregate Meal Services - Over the course of one year, the Flint Department of Parks and Recreation in conjunction with the Genesee County Community Action Agency's Senior Food Program has provided over sixty thousand meals to senior citizens attending the following community centers: Brennan, Berston Fieldhouse, Haskell Community Center, Hasselbring Park Senior Community Center and McKinley Community.

2. Senior Equipment and Unmet Needs - Through various grants from the State Office on Services to the Aging, the Flint Department of Parks and Recreation has secured a total of $26,000 of equipment for five of it's six senior citizen centers over the past two years. The type of equipment varies from tables and chairs to kitchen equipment, coat racks and copy machines.

3. Senior Center Staffing - Over the past four years, the Department of Parks and Recreation has secured over $45,500 in grants from the Valley Area Agency on Aging to provide staff support at city of Flint Senior Centers. For example, Haskell Community Center is now recognized throughout the community for the excellent therapeutic recreation program

> available to people who are older and are recovering from catastrophic illnesses. We are also fortunate to be able to provide intervention in suspected cases of elder abuse through services and counseling provided by a staff member at Hasselbring Center.

Although there are many older people in the city of Flint, who enjoy good health and an adequate income the number of low income frail elderly is increasing. This segment of the population makes up that group of people who demand the most attention from local social service agencies. Through the Older American Act critical nutrition, personal care and homemaker services are available. Although we have an excellent adult day care center in Flint and a limited amount of respite care services available, I take this opportunity today to urge you to recognize the critical need to seek further funding for long term and expanded respite care. Funds are needed to assist families who are caring for a frail spouse or parent at home. Institutionalization too often takes place when an older spouse is physically and emotionally exhausted due to the 24 hour demand of caring for someone with Alzheimer's disease or a related disorder. For many of these people, once placement is made in an adult foster care home or a nursing home the financial drain on a family continues due to the fact that Medicare currently does not pay for extended basic or respite care.

In conclusion, I join my colleagues in urging the Congress to recognize the importance of reauthorizing the Older American Act which is a base of assurance that all citizens regardless of income should feel confident that growing older does not mean growing needy.

Mr. **Kildee**. Thank you, Joanne.
Suzanne?

STATEMENT OF SUZANNE ZERWICK, DIRECTOR, LAPEER COUNTY COMMISSION ON AGING

Ms. **Zerwick**. Congressman Kildee, welcome home.

Mr. **Kildee**. Thank you very much.

Ms. **Zerwick**. And Congressman Sawyer, welcome to Michigan.

The Lapeer County Commission on Aging is privileged to be able to address this distinguished committee as a direct source provider for senior citizens services in Lapeer County and comment publicly on the reauthorization of the Older Americans Act.

I have been honored to serve the County of Lapeer as the Director of the Commission on Aging for three years, a county office in Region V, Genesee, Lapeer and Shiawassee area, statistically representative of 7,243 seniors according to the 1980 Census. Lapeer is a rural community whose senior population is representative of 11.5 percent of the county's general population of 70,038 persons.

In Fiscal Year 85-86, the Commission on Aging's program served 8,274 persons indicating in excess of a 20 percent growth level from the previous year and demonstrative of growth in the population of the persons age 60 and older in our county.

The Older Americans Act of 1965 has signified a national mandate on behalf of the Congress of the United States to provide direct services for our elderly citizens through the aging network which have impacted positively on the quality of life and reduced the possibility of premature institutionalization.

Lapeer County has benefited through the Older Americans Act programming. Senior program participants in Lapeer have received $134,409 in nutrition programming, $36,181 in Title IIIB, home chore senior center staffing and information and referral dollars, occasionally supplemented by state dollars where available and private funding.

In 1988 we will have the access of additional program dollars which have been generated through the first senior citizen millage to be passed in Lapeer County, in essence to serve the priority needs of the homebound, the frail elderly and handicapped residents of Lapeer.

The upward trend in the growth of the elderly population will signal greater demand for services in the future, and increased funding must be provided. Due to the fact that the Older Americans Act program dollars are appropriated through interstate formulas, population base and need, rural areas such as Lapeer whose client base continue to grow, but whose population base is relatively small, sometimes in essence have problems seeking money to develop other types of programmings.

Rural programming is becoming costly to deliver due to lack of proximity to transportation services, increased mileage distances to deliver in-home services such as homebound meals, outreach, information and referral, friendly visiting and telephone reassurance, all critical programs to the elderly who are homebound, handicapped, infirmed, socially isolated and frail.

Urban areas have long been the recipients of federal dollars based on population which have enabled them to offer a more diverse series of programs such as legal services, employment programs, hearing impaired services, adult day care services and minor repair, some of which are not necessarily accessible to rural areas due to the geography, as well as monies to construct senior centers.

Rural programs need financial resources, and that should be I think a priority that we should examine.

Prior to addressing the reauthorization of the Older Americans Act, allow me to address some things that are closer to home.

In Lapeer County the needs of our rural area seniors basically are emergency transportation, homebound outreach, expansion of in-home services, and volunteer incentives, which we feel really need to be developed in order to encourage those persons that are supporting our services with volunteer programs. One of the ones that we cite, for example, is the RSVP Program, which provides us with some sort of volunteer support help.

In rural areas, the majority of our elderly people reside in their homes trying to adequately care for themselves. Many are frail, ill, handicapped, socially isolated and experiencing the physical changes associated with the aging process. Many are without the support of family and friends, yet too proud to acknowledge that they need help and are fearful of surrendering what little independence they may possess to other family members. They fear hospitalization, health insurance problems, catastrophic illnesses, nursing home placement, abandonment, loss of a spouse, which is all we feel mutually—it is all a mutual concern of older people across the country. It is not necessarily just our people in particular.

In rural areas such as ours we serve as the only lifeline sometimes between the senior and the services, which to us is really a sad commentary on things because we are really the only lifeline that they have outside of their home.

While programs sponsored through the Older Americans Act encourage volunteerism, one critical area in the rural elderly's needs are not being met, and that is the emergency medical transportation. Private funded resources such as RSVP, which is the Retired Senior Volunteer Program, give some support with transportation. However, their program restrictions, such as their 15 mile per day limit, their 17 cent per mile reimbursement for mileage, their $1.35 meal reimbursement and their 4 hour day and $20 per month limit allotment, prohibit our assigning out-of-city medical services. Lots of our people have to go to Harper Woods, have to come into Flint, have to go to Ann Arbor, have to go to a lot of different places, and they do not have the family or the support to be able to do that. It becomes increasingly difficult for us to cope in those areas.

Anyone seeking medical services outside of the boundary of the county cannot receive services unless dollar resources can be found someplace else or unless we, in essence, who are not licensed to take on that responsibility, adjust our programming schedule so that we can provide with county vehicles the transportation that needs to be done on an emergency basis.

Homebound outreach has been a need which we have attempted to meet through the provision of United Way funding. We possess a staff person who visits the ill, infirm, homebound and outreaches the socially isolated in our community. In four months of programming, this person has developed a client list of 66 individuals whose immediate needs she meets. And that becomes an increasingly difficult thing too. In venturing out, we didn't think that this was going to be such a great outpouring of need, and it is becoming greater and greater all the time. It is amazing how many people by word of mouth alone and by getting confidence in an individual will pass along the word that someone is providing the service, someone has come into their home. And before you know it, we have a flood of phone calls that lots of times we cannot take care of.

The Older Americans Act has guaranteed retired individuals health, honor and dignity after years of contribution to the economy. However, the false premise that seniors should pay for services still exists. The majority of persons served by the Older Americans Act programs are on limited income facing economic hardship and fearful of what the future will bring them. A lot of them do not have the ability to be able to pay for the programs that they do have. And those that do, donate only what they can, and that has been most acceptable to us. We are very much against people having to pay a set fee for services.

I cannot tell you what that might do to the program alone. And unfortunately, it might leave a lot of really needy people out there not being able to access services because of set fees being set or because of any kind of—you know, institution of anything along that line.

The suggested donation program that we have gone through with the nutrition program has worked relatively well, and I think that rather than mandating any type of set fee that a suggested donation or some sort of a sliding fee scale, if you want to go that route, would be better than doing that.

There has been for the longest time within the nutrition program, I guess, the confusion stemming from suggested donations and free meals, whether or not the meals are actually free and whether or not the donations are suggested or mandatory or whatever. It kind of flip-flops back and forth. It is really kind of an ironic thing in our community because where we have a problem with that is not necessarily the people who cannot donate. It is the people who do donate versus the people who can and won't donate. And I think that crisscrosses back and forth and becomes a problematic kind of thing. If it's ever pointed out that the meals are for free, that really becomes a problem. And due to the fact that most of us have a program income that we have to provide for our nutrition program, and kind of insure in a way, we don't want to give people the impression that the service is totally for free because we run into a problem with that. So, we recommend that the suggested donation remain and that the language still remain that way.

The Lapeer County Commission on Aging is, like I said, opposed to persons paying for services and for set fees. I think most of our people can barely afford it.

Another thing that we run into a problem with is clarification on the age of people who can receive senior services. As you know, the Title V program, which is the senior community service employment program, allows persons 55 and older to come into the program and, in essence, they are deemed as seniors in one aspect. Yet, a couple of years ago when they were allowed to be assigned to nutrition programs to help supportive staff and the age limit was 60, there was always the question of how much do they pay. Can they participate in programming, can't they participate in programming? That becomes a little skeptical.

We have understood that the government would like to change the age limit and would like to probably up the age limit of senior citizens to 65. We would rather—I think most of us would rather see one age. And I would think that deemed it appropriate if persons coming into program can access a Title V program, which is an Older Americans Act program, at the age of 55 that maybe the limit should be set at 55 and not 65.

Older Americans Act programs have been for the past years functioning at maintenance of effort amounts. As the cost of living increases, each of the programs should keep pace with those costs. Service providers are continually meeting more demand with less staff and some staff with barely above minimum wage levels.

The Lapeer County Commission on Aging wishes to publicly acknowledge the dedication of Congressman Kildee to the elderly residents of this State and the Nation as well, his efforts to secure additional financial support for a lot of the programs that we sponsor, as well as alternative care and homebound meals, and trying to educate other legislators on the needs of the elderly as most notable, and we appreciate that.

And I welcome the opportunity on behalf of the Commission on Aging to address this distinguished committee. Thank you.

[The prepared statement of Suzanne L. Zerwick follows:]

Statement of Suzanne L. Zerwick
Director of the Lapeer County
Commission on Aging, Lapeer
Michigan

Congressman Dale Kildee, (D) Flint, Michigan
Congressman Tom Sawyer, (D) Akron, Ohio

The Lapeer County Commission on Aging is priveledged to be able to address this distinguished committee, as a direct service provider of senior citizen services for Lapeer County, and comment publicly on the reauthorization of the Older Americans Act.

I have been honored to serve the County of Lapeer as Director of the Commission on Aging for 3 years, a county office in the Region V (Genesee, Lapeer, and Shiawasee) area statistically representative of 7,243 seniors (according to the 1980 Census). Lapeer is a rural community whose senior population is representative of 11.5% of the Countys' general population of 70,038 persons. In FY 85-86, the Commission on Agings' programs served 8274 persons; indicating in excess of a 20% growth level from the previous year and demonstrative of growth in the population, age 60 plus, in our County.

The Older Americans Act of 1965 has signified a national mandate, on the part of the Congress of the United States, to provide direct services for our elderly citizens, through the aging network, which have impacted positively on quality of life and reduced the possibility of premature institutionalization.

Lapeer County has benefited through Older Americans Act programming; senior program participants in Lapeer receive $134,409.00 in nutrition programming; $36,181.00 in Title IIIB (Home Chore

Staffing, and Information and Referral dollars); occassionally supplemented by additional State dollars where available, and private funding. In 1988, we will have access to additional program dollars generated through the first Senior Services millage to be passed in Lapeer County; to serve priority needs for the homebound, frail, handicapped elderly residents of Lapeer County.

The upward trend in growth of the elderly population will signal greater demand for services in the future, and increased funding must be provided. Due to the fact that Older Americans Act program dollars are appropriated according through intra-state funding formulas, population base, and need, rural areas, such as Lapeer, whose client base continue to grow, must suspend the development of needed programming due to a lack of funding sources. The cost of living in our country continues to escalate; however federal appropriations for senior programs remain relatively stagnated. Rural programming is becoming more costly to deliver due to lack of proximity to transportation service, increased mileage distances to deliver in-home services (i.e. homebound meals, outreach, information & referral, friendly visiting, and telephone reassurance); all critical programs to the elderly who are homebound, handicapped, infirmed, socially isolated and frail. Urban areas have long been the recipients of federal dollars, based on population, which have enabled them to offer a much more diverse series of programs (i.e legal services, employment programs, Hearing Impaired service, Adult Day Care, Minor Home Repair, etc) not accessible to rural areas; as well as monies to construct senior centers. Rural program needs, and financial resources, should be closely examined to assure that rural programs receive their fair share of revenues. Prior to addressing the reauthorization of the Older American Act, allow me to address some closer to home.

In Lapeer County the needs of our rural area seniors are emergency transportation, homebound outreach, expansion of in-home services, volunteer incentives (i.e mileage reimbursement program for emergency medical transportation, and development of a senior center site in Lapeer proper.

In rural areas, such as Lapeer County, the majority of our elderly residents reside in their own homes trying to adequately care for themselves. Many are frail, ill, handicapped, socially isolated and experiencing the physical changes associated with the aging process. Many are without the support of family and friends; and yet too proud to acknowledge that they need help and/or fearful of surrendering what independence they may possess to other family members. They fear hospitalization, health insurance problems, nursing home placement, abandonment and loss of their spouse; a mutual concern of the elderly nationwide. Prior to a addressing the reauthorization of the Older Americans Act, allow me to address some needs closer to home.

In rural areas, such as ours, the Commission on Aging serves as a life-line between the seniors in need and service provision; the majority of the time we are their only link to the world outside their home enivironment; a sad commentary. While programs sponsored through the older Americans Act encourage volunteerism; one critical area in which rural elderlys' needs are not being met is emergency medical transportation. Private funded resources such as the RSVP (Retired Senior Volunteer Program) give some support with transportation; however their program restrictions (i.e. 15 miles perday limit, 17¢ per mile; $1.35 meal reimbursement 4 hr. day and $20.00 per month limit) prohibit our assigning out of city medical transportation or friendly visiting needs.

In Lapeer County anyone seeking medical services, beyond the boundaries of the County limits cannot receive assistance unless other dollar resources can be found to supplement the need. While the LCCOA is not funded to provide emergency medical transportation, we try to accommodate those seeking emergency help by altering program scheduling to do so. Difficulties in meeting special needs arise when drivers must be sought for emergency therapies, cancer treatments (i.e cobalt, Kemotheraphy, etc),necessitating trips to Flint, Ann Arbor, Detroit, and other areas. A special demonstration program, for rural communities, in the area of medical emergency transportation would be very helpful.

Homebound Outreach has been a need which we have attempted to meet through the provision of United Way funding. We possess a staff person who visits the ill, infirmed, homebound,and socially isolated in our community. In 4 months of programming this staff person has developed a client list numbering 66 individuals whose immediate needs she meets; however we anticipate much support is needed in this area as one person cannot adequately meet the individual needs of so many persons. Title IIIB services, in this area, should be considered for future development; dwindling financial resources will dictate our becoming more aware of the critical need which this service provides. In-home services and outreach programs, funded through Title III B should also be expanded.

The Older Americans Act has guaranteed retired individuals health honor, and dignity after years of contribution to the economy; however the false premise that all seniors should pay for services exists. The majority of persons served by Older Americans' Act programs are on limited incomes facing economic hardship and fearful of what the future will bring them; they should not pay for services however donation should be encouraged.

The nutrition program has always been supported through donations; by donations providing needed program income our rural program can purchase better food products, expand service delivery levels, and better meet the nutritional requirements of our participants. The confusion stemming from "suggested donations" and "free meals" is continually a problem. Contractually, we are given a proposed program income figure which we strive to achieve, funding sources continually monitor our progress at achieving program income goals; if people are left with the impression that meals are free then why all the monitoring? Donation levels would decrease drastically with client perceiving that meals are free and donations are not important to the program. It should established that the clients who most complain about the procedure are those who do donate versus those who can afford to donate but fail to do do; to say the least this causes problems. The interpretation of "suggested donation" should be clarified.

The Lapeer County Commission on Aging is opposed to seniors paying for services, charging for services in the furture, and the establishment of set fees, The majority of our clients can barely afford the basic needs of life; the taxes which the pay should provide a direct service which does not demand payment.

Clarification on the age to receive senior programming is confusing, also. Persons needing part time employment opportunities, who meet economic guidelines, can access the Senior Community Service Employment program if they are 55 and older; yet they are not eligible to participate in the senior nutrition program. Years ago, when Title V workers were able to be outplaced in senior centers, the question arose as to what amount of money they would have to pay for lunch (i.e senior donation rate, volunteer rate, or full cost). The age should be set at one participate age requirement; rather than raise the level to 65, the LCCOA supports lowering the participant level from age 60 to 55.

Older Americans Act programs have been, for the last few years, functioning at maintenance of effort amounts; as the cost of living increases each year the program should keep pace with those costs. Service providers are continually meeting more demand with less staff; many staff barely above minumum wage. Maintaining quality staff is difficult, at consistently low wages is difficult.

The Lapeer County Commission on Aging wishes to publicly acknowledge the dedication of Congressman Dale Kildee to the elderly residents of this state. His efforts to secure additional financial support for Alternative Care Services, Homebound meals, and trying to educate other Legislators to the needs of the elderly; nationwide, and are gratefully appreciated.

I welcome the opportunity to address this distinguished committee; your work is vital to our course of bettering the quality of life for our elderly, and we welcome whatever support you can offer us in our efforts to care and advocate for those of whom we have been given charge.   Thank you, very much.

Mr. **Kildee**. Thank you, Suzanne.
Val?

STATEMENT OF VALARIA CONERLY, EXECUTIVE DIRECTOR, VALLEY AREA AGENCY ON AGING

Ms. **Conerly**. Thank you very much. It is certainly my pleasure to be afforded the opportunity to give testimony today, and certainly Congressman Kildee is not a stranger to his own district. I think we know and have a lot of input with Congressman Kildee, have had and hopefully will continue to have. Also to the Congressman from Ohio, it is certainly a great honor to have you in our area, and that you motored down today is certainly significant. And to the staff people, certainly Suzanne has been tremendous in the area of aging over the years.

I would first like to say that I feel very stifled that I cannot speak in the voice of Jesse Jackson and the Honorable Barbara Jordan from past years since this is written public testimony. So, I'll just be myself today.

Once again, to offer testimony on the importance of the reauthorization of the Older Americans Act is very critical. The necessity of the Older Americans Act funded services within our own counties, that being Genesee, Lapeer and Shiawassee counties is clearly demonstrated by a few simple statistics given from Fiscal Year 1984 to Fiscal Year 1986 our in-home service case load increased by 56 percent. The hours per week of in-home assistance provided to each client is severely restricted in order to serve as many people as possible. The home delivered case load has increased by 25 percent. A very small volunteer transportation program has more than doubled the number of seniors served without any increase in funding.

As far as local involvement, the public input into our local planning process is key to the effectiveness of the Older Americans Act. Our annual planning process includes approximately four months of public meetings in each of our three counties. Local seniors and service providers work very hard with our staff to identify priorities for funding and develop program development strategies which will effectively impact on gaps in the service network. This community based planning process, which far exceeds federal and state requirements for public input, has significantly enhanced the effectiveness of a comprehensive and coordinated service delivery system for the elderly of our particular region. I certainly would ask that consideration be given to the planning process on our own local level as a model to other area agencies which certainly insures that the Older Americans Act funds truly impact on local needs.

Each year our program development action plan outlines specific objectives to impact on the many service needs which we are unable to fund. Community participation in developing the plan feeds into our extensive and flexible advisory committee structure which goes along with our staff and assistants with the implementation of the many objectives throughout the given year. Through these program development objectives, once again these are objectives that we work on that are not fundable through the Older Americans Act but demand extra attention.

Some of the accomplishments have been coordination and consolidation of transportation resources within Genesee County. Informational publications produced at a minimal cost have helped to promote the concepts of respite care and home sharing. Voluntary speakers bureaus have disseminated information throughout the region on the impact of DRGs, wise use of prescription drugs, and the benefits of hiring older workers.

Several major information and advocacy events are organized each year. Community volunteers are constantly being trained to provide outreach to the isolated elderly. Once again, all of these accomplishments which use no contracted service funds were made possible through the extensive community involvement and the objectives of the area agency.

The most grave issue that I would like to address to the committee today is the declining minority participation in the Older Americans Act programs. You are probably aware of the House Select Committee on Aging's finding that minority participation in Title IIIB support services dropped by 25 percent from the Fiscal Year 1980 to 1985.

In the State of Michigan the actual number of minority persons participating in the congregate meal program demonstrates a shocking decline: from over 37,000 individuals in Fiscal Year 1981 to less than 21,000 in Fiscal Year 1986. In only one year between 1985 to 1986, 9 out of 14 area agencies on aging in Michigan experienced a decrease in the number of minority congregate meal participants.

The number of minority home delivered meal recipients in Michigan has increased at a snail's pace compared to the dramatic overall growth in that particular program. Between the years of 1985 to 1986, the minority proportion of home delivered meal participants declined from 15 percent to 13 percent. In that same given year there was a significant growth in home delivered meals overall while we experienced a decrease in the actual number of minorities served by that particular program.

The facts are clear in my estimate. The socially and economically disadvantaged have been taken advantage of in this particular decade. At a minimum, the regulatory language which specifically required targeting of minorities must be restored to the Older Americans Act. I further support the proposals of the National Caucus of the Black Aged and Representative Roybal that targeting of services to minorities must be in proportion to the economic need of the minority group.

A concerted effort is necessary throughout the aging network to correct such a travesty. Adequate minority staffing in state agencies, area agencies and local service providers is a must. Area agencies must begin to examine procedures which guarantee excess to service to insure that technical procedures are appropriately conveyed to each ethnic group. Training and technical assistance for local minority organizations must be expanded. Each area agency must assess the effectiveness of its outreach to minorities and improve those outreach techniques until the disadvantaged and minorities are receiving their fair share of Older Americans Act services. The commitment and technical assistance to comply with this mandate must be demonstrated beginning at the federal level on to the state and certainly local level.

A few comments on the sliding fee scale. Certainly in accordance with the testimony given by Suzanne Zerwick, the Administration's proposal to allow fees based on ability to pay for Title IIIB services would devastate the basic concepts of the Older Americans Act. That concept includes the fact that seniors, who have worked all of their lives, may be in need of support services irregardless (sic) of income. The current voluntary donation provisions recognize the importance of extending services with dignity to all economic groups. Fees based on ability to pay will introduce a means test, something originally that the Older Americans Act has consistently prohibited in order to avoid poor services for poor people, in other words, the whole welfare stigma being attached to a program that we viewed as being a very dignified program to allow individuals to remain independent and in their own homes.

The economically marginal senior citizen is already overwhelmed by a quagmire of incompatible public assistance programs. Excessive housing expenses are not considered on a Medicaid application. Medical expenses are not considered when the senior seeks emergency assistance with an excessive utility bill. Please, do not add the Older Americans Act support services to what we deem as being a humiliating and life-threatening maze. We are pleased to accept the contributions which each senior can afford.

During the course of the week, this particular local area agency conducted several public hearings within our three county area. Two points were brought out time and time again. Number one, we must strive to eliminate an image of government services for the poor from our programs in order to reach all of those individuals who are truly in need.

Number two, oftentimes seniors are refusing services because they cannot afford the suggested contribution. Once again, I appear before you today with a clear mandate from the local seniors within our given area to oppose the introduction of a means test or the imposition of a sliding fee scale.

Two other areas, and it is really going to be brief at this point. I certainly am in opposition to the Administration's proposal to amend the formula for allotments to states based on population aged 65 and older. The health conditions which necessitate support services strike the disadvantaged, who have experienced a lifetime of inadequate health care even before age 60. Minorities in particular are denied the benefits of programs as the age criteria is raised due to the shorter life expectancy. As our mandate should continue to serve all persons over 60, so should our funding be allocated.

I believe my initial statistics demonstrate the need for the influx of additional funds for the services to the frail elderly proposed by our Honorable Representative Kildee. Please note that an adequate administrative base certainly is necessary to insure effective use of increased funds and still perform other area agency on aging mandates of advocacy and program development in a quality fashion. In considering the administrative cap on OAA programs, I suggest that the committee compare our current cap to other federal human service programs.

In conclusion, once again, I would like to thank Congressman Kildee for allowing me the opportunity to present what I consider very valuable information and thank you again for your time and your attention today.

[The prepared statement of Valaria Conerly follows:]

TESTIMONY ON REAUTHORIZATION OF THE OLDER AMERICANS ACT

Valeria Conerly, Executive Director

Valley Area Agency on Aging

I AM VERY HAPPY TO HAVE THIS OPPORTUNITY TO OFFER TESTIMONY ON THE IMPORTANCE OF THE REAUTHORIZATION OF THE OLDER AMERICANS ACT. THE NECESSITY OF OAA-FUNDED SERVICES IN GENESEE, LAPEER, AND SHIAWASSEE COUNTIES IS CLEARLY DEMONSTRATED BY A FEW SIMPLE STATISTICS. FROM FISCAL YEAR 1984 TO FISCAL YEAR 1986, OUR IN-HOME SERVICE CASELOAD INCREASED BY 56%. THE HOURS PER WEEK OF IN-HOME ASSISTANCE PROVIDED TO EACH CLIENT IS SEVERELY RESTRICTED IN ORDER TO SERVE AS MANY PEOPLE AS POSSIBLE. THE HOME DELIVERED MEAL CASELOAD HAS INCREASED BY 25%. A VERY SMALL VOLUNTEER TRANSPORTATION PROGRAM HAS MORE THAN DOUBLED THE NUMBER OF SENIORS SERVED WITHOUT ANY INCREASE IN FUNDING.

LOCAL INVOLVEMENT

PUBLIC INPUT IN THE LOCAL PLANNING PROCESS IS KEY TO THE EFFECTIVENESS OF THE OLDER AMERICANS ACT. OUR ANNUAL PLANNING PROCESS INCLUDES APPROXIMATELY FOUR MONTHS OF PUBLIC MEETINGS IN EACH OF OUR THREE COUNTIES. LOCAL SENIORS AND SERVICE PROVIDERS WORK VERY HARD WITH OUR STAFF TO IDENTIFY PRIORITIES FOR FUNDING AND DEVELOP PROGRAM DEVELOPMENT STRATEGIES WHICH WILL EFFECTIVELY IMPACT ON GAPS IN THE SERVICE NETWORK. THIS COMMUNITY-BASED

PLANNING PROCESS, WHICH FAR EXCEEDS FEDERAL AND STATE REQUIREMENTS FOR PUBLIC INPUT, HAS SIGNIFICANTLY ENHANCED THE EFFECTIVENESS OF A COMPREHENSIVE AND COORDINATED SERVICE DELIVERY SYSTEM FOR THE ELDERLY OF OUR REGION. I RECOMMEND OUR PLANNING PROCESS AS A MODEL TO OTHER AREA AGENCIES WHICH ENSURES THAT OAA DOLLARS TRULY IMPACT ON LOCAL NEEDS.

EACH YEAR, OUR PROGRAM DEVELOPMENT ACTION PLAN OUTLINES SPECIFIC OBJECTIVES TO IMPACT ON THE MANY SERVICE NEEDS WHICH WE ARE UNABLE TO FUND. COMMUNITY PARTICIPATION IN DEVELOPING THE PLAN FEEDS INTO AN EXTENSIVE AND FLEXIBLE ADVISORY COMMITTEE STRUCTURE WHICH ASSISTS OUR STAFF WITH IMPLEMENTATION OF THE PROGRAM DEVELOPMENT OBJECTIVES THROUGHOUT THE YEAR. RECENT PROGRAM DEVELOPMENT ACCOMPLISHMENTS HAVE INCLUDED COORDINATION AND CONSOLIDATION OF TRANSPORTATION RESOURCES WITHIN GENESEE COUNTY. INFORMATIONAL PUBLICATIONS, PRODUCED AT MINIMAL COST, HAVE PROMOTED THE CONCEPTS OF RESPITE CARE AND HOMESHARING. VOLUNTARY SPEAKERS BUREAUS HAVE DISSEMINATED INFORMATION THROUGHOUT OUR REGION ON THE IMPACT OF DRGs, WISE USE OF PRESCRIPTION DRUGS, AND THE BENEFITS OF HIRING OLDER WORKERS. SEVERAL MAJOR INFORMATION AND ADVOCACY EVENTS ARE ORGANIZED EACH YEAR FOR AND BY SENIOR CITIZENS. COMMUNITY VOLUNTEERS ARE BEING TRAINED TO PROVIDE OUTREACH TO THE ISOLATED ELDERLY. ALL OF THESE ACCOMPLISHMENTS, WHICH USED NO CONTRACTED SERVICE FUNDS, WERE MADE POSSIBLE THROUGH EXTENSIVE COMMUNITY INVOLVEMENT IN THE OBJECTIVES OF THE AREA AGENCY.

MINORITY PARTICIPATION

THE MOST GRAVE ISSUE WHICH I MUST ADDRESS TO THE COMMITTEE TODAY IS THE DECLINING MINORITY PARTICIPATION IN OAA PROGRAMS. YOU ARE PROBABLY AWARE OF THE HOUSE SELECT COMMITTEE ON AGING FINDING THAT MINORITY PARTICIPATION IN TITLE III-B SUPPORT SERVICES DROPPED BY 25% FROM FISCAL YEAR 1980 TO 1985.

IN THE STATE OF MICHIGAN, THE ACTUAL NUMBER OF MINORITY PERSONS PARTICIPATING IN THE CONGREGATE MEAL PROGRAM DEMONSTRATES A SHOCKING DECLINE, FROM OVER 37,000 PERSONS (21% OF TOTAL) IN FISCAL YEAR 1981 TO LESS THAN 21,000 PERSONS (15% OF TOTAL) IN FY"86. IN ONLY ONE YEAR, FROM FY'85 TO '86, NINE OUT OF FOURTEEN AAAs IN MICHIGAN EXPERIENCED A DECREASE IN THE NUMBER OF MINORITY CONGREGATE MEAL PARTICIPANTS.

THE NUMBER OF MINORITY HOME DELIVERED MEAL RECIPIENTS IN MICHIGAN HAS INCREASED AT A SNAIL'S PACE COMPARED TO THE DRAMATIC OVERALL GROWTH IN THAT PROGRAM. FROM FY'85 TO FY'86, THE MINORITY PROPORTION OF HOME DELIVERED MEAL PARTICIPANTS DECLINED FROM 15% TO 13%. IN THAT SAME YEAR, FIVE AAAs WHICH DEMONSTRATED SIGNIFICANT GROWTH IN THEIR HOME DELIVERED MEAL PROGRAMS ALSO DEMONSTRATED A DECREASE IN ACTUAL NUMBER OF MINORITIES SERVED BY THAT PROGRAM.

THE FACTS ARE CLEAR. THE SOCIALLY AND ECONOMICALLY DISADVANTAGED HAVE BEEN TAKEN ADVANTAGE OF IN THIS DECADE. AT A MINIMUM, THE REGULATORY LANGUAGE WHICH SPECIFICALLY REQUIRED TARGETING OF MINORITIES MUST BE RESTORED TO THE OLDER AMERICANS ACT. I FURTHER SUPPORT THE PROPOSALS OF THE NATIONAL CAUCUS ON THE BLACK AGED AND REP. ROYBAL THAT TARGETING OF SERVICES TO

MINORITIES BE IN PROPORTION TO THE ECONOMIC NEED OF THE MINORITY GROUP.

A CONCERTED EFFORT IS NECESSARY THROUGHOUT THE AGING NETWORK TO CORRECT THIS TRAVESTY. ADEQUATE MINORITY STAFFING IN STATE AGENCIES, AREA AGENCIES, AND LOCAL SERVICE PROVIDERS IS A MUST. AREA AGENCIES MUST EXAMINE PROCEDURES WHICH GUARANTEE ACCESS TO SERVICE TO BE SURE THAT TECHNICAL PROCEDURES ARE APPROPRIATELY CONVEYED TO EACH ETHNIC GROUP. TRAINING AND TECHNICAL ASSISTANCE FOR LOCAL MINORITY ORGANIZATIONS SHOULD BE EXPANDED. EACH AREA AGENCY MUST ASSESS THE EFFECTIVENESS OF ITS OUTREACH TO MINORITIES AND IMPROVE THOSE OUTREACH TECHNIQUES UNTIL THE DISADVANTAGED AND MINORITIES ARE RECEIVING THEIR FAIR SHARE OF OAA SERVICES. THE COMMITMENT AND TECHNICAL ASSISTANCE TO COMPLY WITH THIS MANDATE MUST BE DEMONSTRATED AT THE FEDERAL AND STATE, AS WELL AS THE LOCAL, LEVEL.

SLIDING FEE SCALE

THE ADMINISTRATION PROPOSAL TO ALLOW FEES BASED ON ABILITY TO PAY FOR TITLE III-B SERVICES WOULD DEVASTATE THE BASIC CONCEPTS OF THE OLDER AMERICANS ACT. THAT CONCEPT INCLUDES THE FACT THAT SENIORS WHO HAVE WORKED ALL THEIR LIVES MAY BE IN NEED OF SUPPORT SERVICES, IRREGARDLESS OF INCOME. THE CURRENT VOLUNTARY DONATION PROVISIONS RECOGNIZE THE IMPORTANCE OF EXTENDING SERVICES WITH DIGNITY TO ALL ECONOMIC GROUPS. FEES BASED ON ABILITY TO PAY WILL INTRODUCE A MEANS TEST, SOMETHING THE OAA HAS CONSISTENTLY PROHIBITED IN ORDER TO AVOID POOR SERVICES FOR POOR PEOPLE.

THE ECONOMICALLY MARGINAL SENIOR CITIZEN IS ALREADY OVERWHELMED BY A QUAGMIRE OF INCOMPATIBLE PUBLIC ASSISTANCE PROGRAMS. EXCESSIVE HOUSING EXPENSES ARE NOT CONSIDERED ON A MEDICAID APPLICATION. MEDICAL EXPENSES ARE NOT CONSIDERED WHEN THE SENIOR SEEKS EMERGENCY ASSISTANCE WITH AN EXCESSIVE UTILITY BILL. PLEASE DO NOT ADD OUR OAA SUPPORT SERVICES TO THIS HUMILIATING AND LIFE-THREATENING MAZE. WE ARE PLEASED TO ACCEPT THE CONTRIBUTIONS WHICH EACH SENIOR CAN AFFORD.

OUR AGENCY HELD PUBLIC HEARINGS ON OUR ANNUAL PLAN IN EACH OF OUR THREE COUNTIES THIS WEEK. THE SENIORS VOLUNTEERED TWO POINTS LOUD AND CLEAR:

1. WE MUST ELIMINATE AN IMAGE OF GOVERNMENT SERVICES FOR THE POOR FROM OUR PROGRAMS IN ORDER TO REACH ALL WHO ARE TRULY IN NEED.

2. SOME SENIORS ARE REFUSING SERVICES BECAUSE THEY CANNOT AFFORD THE SUGGESTED CONTRIBUTION.

THUS, I APPEAR BEFORE YOU TODAY WITH A CLEAR MANDATE FROM THE LOCAL SENIORS TO OPPOSE THE INTRODUCTION OF A MEANS TEST OR THE IMPOSITION OF ANY SLIDING FEE SCALE.

SET ASIDE FOR PRIORITY SERVICES

I SUPPORT CURRENT LANGUAGE THAT AN "ADEQUATE AMOUNT" OF THE AAA SOCIAL SERVICE ALLOTMENT BE ALLOCATED TO ACCESS, IN-HOME, AND LEGAL SERVICES. WHILE WE RECOGNIZE THE NECESSITY OF THESE PRIORITIES, WE DO NOT SEE A NEED TO ESTABLISH SPECIFIC PERCENT SET

ASIDE AT THE FEDERAL LEVEL. RESTORATION OF THIS PROVISION WOULD HINDER LOCAL FLEXIBILITY TO ASSESS NEEDS AND THE AVAILABILITY OF OTHER RESOURCES WITHIN OUR OWN REGION.

CHANGE IN THE AGE FOR THE STATE ALLOTMENT FORMULA

I OPPOSE THE ADMINISTRATION PROPOSAL TO AMEND THE FORMULA FOR ALLOTMENTS TO STATES BASED ON POPULATION AGED 65 AND OVER. THE HEALTH CONDITIONS WHICH NECESSITATE SUPPORT SERVICES STRIKE THE DISADVANTAGED, WHO HAVE EXPERIENCED A LIFETIME OF INADEQUATE HEALTH CARE, EVEN BEFORE AGE 60. MINORITIES IN PARTICULAR ARE DENIED THE BENEFITS OF PROGRAMS AS THE AGE CRITERIA IS RAISED DUE TO THE SHORTER LIFE EXPECTANCY. AS OUR MANDATE SHOULD CONTINUE TO SERVE ALL PERSONS OVER AGE 60, SO SHOULD OUR FUNDING BE ALLOCATED.

ADEQUATE ADMINISTRATIVE ALLOTMENT

I BELIEVE MY INITIAL STATISTICS DEMONSTRATE THE NEED FOR THE INFLUX OF ADDITIONAL FUNDS FOR SERVICES TO THE FRAIL ELDERLY PROPOSED BY REP. KILDEE. PLEASE NOTE THAT AN ADEQUATE ADMINISTRATIVE BASE IS NECESSARY TO ENSURE EFFECTIVE USE OF INCREASED FUNDS AND STILL PERFORM OTHER AAA MANDATES OF ADVOCACY AND PROGRAM DEVELOPMENT IN A QUALITY FASHION. IN CONSIDERING THE ADMINISTRATIVE CAP ON OAA PROGRAMS, I SUGGEST THAT THE COMMITTEE COMPARE OUR CURRENT CAP TO OTHER FEDERAL HUMAN SERVICE PROGRAMS.

I APPRECIATE THE OPPORTUNITY TO PRESENT THIS INFORMATION AND THANK YOU FOR YOUR ATTENTION.

Mr. **Kildee**. Thank you very much, Val.

Our next witness in this panel has worn several hats through the years, National Chairperson of the National Association of Counties, County Commissioner, and good friend. Charlotte?

STATEMENT OF CHARLOTTE WILLIAMS, MEMBER, MICHIGAN COMMISSION ON AGING

Ms. **Williams**. Thank you very much, Mr. Kildee. Dale, I am awfully glad to say welcome to you at home. I don't get to see you often, so I just take this minute to be personal. And to you, Mr. Sawyer, thanks for coming to Flint, Genesee County. Welcome to staff.

My name is Charlotte Williams and I am the State aging commissioner from Flint. I do appreciate the opportunity to testify on the reauthorization of the Older Americans Act. My comments will be brief, but I hope you will listen and take heed to our concerns.

One, the reauthorization period. The Older Americans Act should be reauthorized for a period of three years or through September 30, 1990. The current language regarding multi-year state plans should be retained.

Two, placement of the administration on aging. An assistant secretary for aging should be established within the Department of Health and Human Services with responsibility for representing the interest of all older Americans within DHHS and with other federal departments and agencies, and for administering the Older Americans Act. The advocacy role of OAA is very important, and may be the most important function of that position.

Three, direct services. Language prohibiting direct services by area agencies should be retained, but access services such as information and referral, outreach and case management should be allowed.

Four, advocacy. State and area agencies should continue to serve as advocates on matters concerning older persons. This includes review and comment on state and federal plans, budgets and policies which affect the elderly.

On commodities I support the proposed 10 percent increase in the authorization of appropriation for USDA commodity distribution.

The ombudsman, the Long-Term Care Ombudsman program, should be a separate subsection of Title III with a separate authorization of appropriation.

Part D. The proposed part D for in-home services is long overdue. The increased demand for in-home services warrants special attention.

On Title V, the national contractors should be required to cooperate with the state units on aging in developing a statewide plan for the allocation of job slots in each state.

Again, I would like to thank you for the opportunity to comment on the proposed reauthorization and add to the many concerns that have been voiced here before me and that will be voiced after me on the reauthorization of the Older Americans Act.

Thank you.

[Prepared statement of Charlotte Williams follows:]

PREPARED STATEMENT OF CHARLOTTE WILLIAMS, STATE COMMISSIONER, FLINT, MI

My name is CHARLOTTE WILLIAMS, I am a State Commissioner from Flint. I appreciate the opportunity to testify on Reauthorization of the Older Americans Act. My comments on Reauthorization are as follows:

1. REAUTHORIZATION PERIOD

   The Older Americans Act should be reauthorized for a period of three years, or through September 30, 1990. The current language regarding multi-year state plans should be retained.

2. PLACEMENT OF THE ADMINISTRATION ON AGING

   An Assistant Secretary for Aging should be established within the Department of Health and Human Services with responsibility for representing the interest of all older Americans within DHHS and with other federal departments and agencies; and for administering the Older Americans Act. The advocacy role of the head of AoA is very important and may be the most important function of the position.

3. DIRECT SERVICES

   Language prohibiting direct services by Area Agencies should be retained, but access services such as Information and Referral, Outreach and Case Management should be allowed.

4. ADVOCACY

   State and Area agencies should continue to serve as advocates on matters concerning older persons. This includes review and comment on State and Federal plans, budgets, and policies which affect the elderly.

5. COMMODIITES.

I support the proposed 10% increase in the authorization of appropriation for USDA commodity distribution.

6. OMBUDSMAN

The Long Term Care Ombudsman program should be a separate subsection of Title III with a separate authorization of appropriation.

7. PART D

The proposed Part D for In-Home Services is long overdue. The increased demand for in-home services warrants special attention.

8. TITLE V

The national contractors should be required to cooperate with the State Units on Aging in developing a statewide plan for the allocation of job slots in each state.

Again, I would like to thank you for the opportunity to comment on the proposed Reauthorization.

Mr. Kildee. Thank you very much.

At previous hearings on the Older Americans Act, we have had witnesses point out that very often older individuals are more likely to seek assistance through Older Americans Act programs than from other sources which they may view as a welfare program. Would you care to comment on that? Do you find that to be the experience?

Ms. Zerwick. I think that is very true especially with our county. We have had a unique kind of a situation because I think, as Val recollects, quite a while ago our program literally commenced with DSS involvement to begin with, and I think we have had more of that stigma than we can take. And then somewhere along the line about a year or two before I came on, the meals that were being given at the end of the day for DSS workers—they had a specific name for the program. It doesn't come to mind right now—also emanated from the senior center, which also—even more associated with it. And it became very difficult.

One of the things that we had to do was disassociate ourselves from that particular program in order to get people to start accessing our program. There are a lot of people that are threatened I think by DSS involvement. To them it represents probably even a larger segment of the bureaucracy than we do because for one thing the forms and the necessary paper work and the in-depth involvement in them knowing about your private life is a lot more than any of us ever require on our programming. And so, there is that Big Brother looking out kind of attitude that they really don't like. They are more apt to come to us for services, and so are their families as well—their younger family members.

Ms. Hartranft. Congressman Kildee, if I could just add one thing to that. I think that ideally if we can work jointly with the departments of social services to provide adequate health care and certainly care to families who are facing the placement of someone in a nursing home or a foster care home needing assistance in the home—we are fortunate I think in Genesee County in having a very good adult foster care home, staff, and nursing home staff assistance through our local department of social services office. And although everything that Suzanne says is true about older people being actually scared of going downtown to get assistance, I think that ideally, if we can work jointly with them to dispel the negative impression that people have of seeking help from the state.

Mr. Kildee. One thing I have noticed here in Flint when you go into a congregate meal setting is that the people are made to feel very dignified. I think I have noticed that probably more than the food. I think the food is very important. They really feel that they are not in some soup line. They are treated with respect and with dignity. It is the same in Imlay City and at the old center building in Lapeer too. That's very important because they have paid their dues through the years. They paid their taxes. They built this country and should not feel that they have to be on a dole. That is one of the features we want to make sure we retain and not have that denigrated through some changes in Washington.

Very often they're trying to take some pressure off the Treasury, so they put some pressure over here to establish a fee schedule. But without a fee schedule, I have noticed the voluntary contribution works very well. I have never seen a welfare attitude at the Detroit Street Center or the other centers there because the option of contributing is always there without saying here's a sliding scale. You had better do thus and thus. So, I think the option of giving protects against a welfare type of feeling there.

Ms. **Conerly**. I think too, Congressman Kildee, in tune with your comments, the important item to remember is that these are individuals that have truly paid their way into the system. So, to superimpose another fee for service to me is utterly ridiculous. And those are some of the comments that we have heard throughout our course of public hearings this week, that we have paid our way into the system. So, why would you tax us further in particular when we are remaining in our own homes, hopefully independent, and with dignity, paying taxes still? And then to pay a fee for service is something beyond the imagination and truly the purses of individuals that are 60 and over.

Mr. **Kildee**. You know what they did better than we are doing right now? They were paying their bills more than we are paying our bills today.

Ms. **Conerly**. That's true. No plastic.

Mr. **Kildee**. They would have been ashamed of deficits that we are running today. They were paying their bills. They were paying for the cost of government in their day.

Ms. **Conerly**. That's right.

Mr. **Kildee**. Our greatest sin right now is we're buying this much government now and then sending a good portion of the bill on to the next generation. They didn't do that very much. Maybe in wartime because we had a crisis, but they didn't do that in ordinary times—have these huge deficits. They were paying for the government of their day and not sending us the bill.

Tom?

Mr. **Sawyer**. Let me follow up on the points that you have begun.

That social environment that keeps the setting pleasant, at least in some of the congregate centers in my city, and according to some of the testimony that we have heard in earlier hearings before this subcommittee suggest that in some settings this is an enormously inclusive kind of thing and very beneficial. However, in other situations, there was the potential to create an in and out group environment in which at least on a friendship basis there were some people who may have felt less participatory than others perhaps even affecting their ability or willingness to participate in a voluntary contribution program.

How do we get around that? How do we deal with that? Or is that not something that falls within your experience?

Ms. **Hartranft**. In terms of when someone comes to a congregate meal——

Mr. **Sawyer**. Yes.

Ms. **Hartranft** [continuing]. And feels that they should pay something and cannot pay something? Is that what you're asking?

Mr. **Sawyer**. Yes. I guess what I am getting at is the significant drop in minority participation. And what the causes behind that might be, and how we deal with that without disrupting what I think is an enormously beneficial environment.

Ms. Conerly. I think in response to that, over the years at our national area agency conferences one thing I've heard, especially from directors coming from the southern states of the country, is that oftentimes programs are available, but minorities do not participate through lack of awareness or whatever the problem is. Low participation has notoriously been under what the allotted dollar amounts are being given to southern states.

One of the things I have addressed is certainly if you are looking at outreach to identify minority participants within a given community, I think it is very unrealistic to believe that oftentimes minority staff individuals are more prone to going into those communities and encouraging and getting that kind of participation. So, I guess overall from the top down within the Older Americans Act you have very few minority staff individuals I think which, in turn, triggers low minority participation.

I think another key thing is targeting programs within a community towards the minority community within its own total scope. It is not enough to have a center for all of the people in a given community and believe that Spanish speaking people will involve themselves, who truly have a dietary and ethnocentricity different from a lot of other older Americans. When you have minority individuals that may never had had any paying job, so were poor in their 20s, became poorer in their 40s, and were under the poverty guidelines at 60 and above, you cannot honestly assume that those people will feel comfortable in a country club environment. So, I think more and more emphasis has to be put on, once again—targeting is very crucial.

In some of the amendments I think in 1973 when we did have the language involved of minorities written right into the law, we saw a lot more minority participation because it was a mandate. It was something people had to do whether they chose to do it or not. When we took those words out and put in "socially and economically disadvantaged," that gave most people an opportunity to skirt the issue of the difficult task of identification of minorities and how do we bring them into the system.

So, unfortunately laws do work. Unfortunately for some. Fortunately for myself laws do carry a crucial part in serving the people that should be served under this particular program.

Mr. Kildee. The Administration has proposed that there be a fee for all the services under part B of Title III. In the congregate setting, it is currently pretty anonymous. If you had to buy a pair of shoes that month, maybe you cannot give anything that month or give less. But if they were to charge a fee for some of these in-home services in part B, there could be no anonymity whether you have given or not. You would lose that, wouldn't you?

What do you think of the administration's proposal in general of permitting the states to charge fees for those supportive services under part B?

Ms. Conerly. I think basically you would see participation drastically decline, I think, because you are getting involved in competitiveness of the dollar. I would believe—and certainly this is just an assumption of mine—if I have the dollars to purchase services and I had a choice between a private entity and a government-funded, I would make the assumption that I would go towards private simply because I have already paid for the government program. And I am not going to continuously pay that same government. I am going to go to the private sector through whatever. If I have to go without a meal, I am going to go into the private sector.

And once again, the intent of the Older Americans Act originally was to serve all people and specifically those people that could not afford through their own means to have the same services as all other Americans. That is my position.

Ms. **Hartranft**. Congressman?

Mr. **Kildee**. Joanne?

Ms. **Hartranft**. I think that one of the—certainly the groups of people that would be drastically affected by this would be the very frail elderly who are confused and are isolated in their own homes. They oftentimes do not understand who they are calling, and who they are speaking to, and really what they are asking for, other than the fact that they know that they need help.

There was an older man I spent a lot of time with—in his 90s living by himself in the City of Flint—and fortunately was receiving mobile meals, but felt that he had to pay for his mobile meals regardless of how many of us tried to explain to him that that was a voluntary contribution. I cannot imagine how he would benefit from having to face a sliding fee scale for other services as well. It would completely overwhelm him, I am sure, and he could not afford to pay it. It would be one more reason, I feel, that people like him who are the most needy and the most fragile in terms of remaining at home and not being served.

Mr. **Kildee**. Suzanne?

Ms. **Zerwick**. The homebound are definitely—above all I think are a most critical group and our most important group and certainly the group that we are probably the most involved with on a daily basis whether it is emotional or physical, you know. We are the ones that are constantly trying to extend whatever services we can to help them even if it is above and beyond what we are funded to do because we know that their situation is drastic.

This type of thing that is being proposed is also, in essence, going to affect largely the congregate people, especially those who use public transportation. Now, if you are talking about donating a dollar for a meal for the day, most people are pretty much assessed of the fact that a dollar is fair. I mean, where in the world can you eat a good meal, a good nutritionally balance meal, for a dollar? Most people really strive to give the top donation. And we have been real fortunate in our particular group to at least see our donations go up. But once public transportation came into Lapeer a few weeks ago, we found that it was a dollar going one way, a dollar coming back, and then a dollar for lunch. Well, when you think about it, that's three dollars a day. If they go five days a week, that's 15 dollars a week for people that are living on limited income who barely have money to purchase their own prescriptions, but yet want to go to the center for that socialization, need to be with somebody else especially those who have lost a spouse. That is drastic.

Those are the people that I think you were alluding to, Congressman Sawyer, who kind of sometimes coming in might be a little bit more removed and a little bit more distant. That is a uniquely and traumatic thing to go through. I watched my mother go through that when she was 40 years old, and it was devastating. I mean, to lose the—you know, everything changes. Your friends change. Your family structure changes. Everything alters when a spouse dies. And these people do come into the program. Sometimes that is the only contact they have with somebody else.

I would feel—I don't know. I would have a very difficult time with that because those people need it so badly.

Mr. **Kildee**. Charlotte?

Ms. **Williams**. I think also you would lose the people, Congressman, that cannot afford to pay for these things because they would in turn feel that I have earned this right all of my life, and if I am going to pay for it, then I am going to go to the movies or we will get together, have lunch and these kinds of things because these people are part of the group that comes to your local centers. And maybe many of these people have had lots of experience in socialization, and they help to bring other people out of their so-called little cocoons and to participate in these kinds of things. And they would back away because they wouldn't really have to go, not that they couldn't afford to pay more. So, you would lose your entire focus of your senior center.

Mr. **Kildee**. I have the advantage of representing a district that is rather a microcosm of America. I have an industrial city with minority groups and neighborhoods that need rebuilding. I have the wealthy suburbs and I have agricultural areas. Lapeer County was given to me as a great gift a few years ago, and I really enjoy it because it has really opened things up for me because almost any bill that comes before the Congress of the United States impacts upon the Seventh Congressional District. I have dairy farmers and wheat farmers.

Ms. **Zerwick**. Migrant workers.

Mr. **Kildee**. And migrant workers. I have every type.

And I noted that in the bill, the bill requires that the area plan must provide assurances for special emphasis for the rural elderly. It says the area plan must provide that. But I recognize that it is probably more costly to provide those services because of the geography and the distances. And perhaps we have to be more sensitive to this and to make sure we recognize that there is a greater cost for transportation in those areas.

Ms. **Zerwick**. I have to say, though, we have been real—well, we are certainly at least real proud to have people like yourself, people like Mrs. Maynard, people like Val who listen to those concerns and who are aware of those concerns. Those are primary concerns to people that I represent, and they are very much heard I feel by the people who represent us.

Mr. **Kildee**. I have no further questions. Thank you very much. Ms. **Williams**.

Ms. **Zerwick**. You are welcome.

Mr. **Kildee**. Our next panel: Jean Blue, Staff Assistant, Senior Citizens Service; and Steve Walker, Director of the Senior Citizen Food Program, Genesee County Community Action Agency. We welcome both of you here today.

OK, Jean, do you want to lead off?

Ms. **Blue**. Yes, thank you.

STATEMENT OF JEAN BLUE, STAFF ASSISTANT, SENIOR CITIZENS SERVICES

Ms. **Blue**. Mr. Chairman, and Congressman Sawyer, my name is Jean Blue, and I serve as director of Senior Citizens Services for the Flint Board of Education. I have worked in this capacity for seven years and am responsible for supervision of programs which have positively affected the lives of thousands of senior citizens in our area. I have come to appreciate the great benefit of the partnership between local, state and federal governments, along with private enterprise to improve the quality of life for older Americans, the fastest growing population segment in the United States.

We are all pleased, Mr. Chairman, that our very own Congressman, who has demonstrated a life-long deep concern and commitment to older citizens, chairs this important committee and has scheduled this hearing in our district.

We are also pleased to have had as a regular participant in our senior club program at Washington School until her recent incapacitation the mother of the committee chairman, Mrs. Norma Kildee, who in her genteel manner could provide the committee through its chairman with special positive inputs about our program.

Mr. **Kildee**. She will be back as soon as springtime arrives. She assured me of that.

Ms. **Blue**. Great.

I would like to direct my brief remarks today to one of my areas of responsibility, the senior aide program, which is funded under Title V of the Older Americans Act. I am also here to support passage of H.R. 1451.

Four years ago Flint Community Schools received a grant from one of the eight national sponsors, the National Council of Senior Citizens, which we call NCSC, to operate a Title V program in Genesee County. Until 1983 Genesee County had only been served by our area agency on aging via a state contract and it was for a limited amount of positions.

When we started the senior aide program, we had 200 senior citizens 55 and older who applied for only 42 jobs. As we were taking applications, I made a decision that if there were that many senior citizens in our community who were looking for and needing jobs, we were not going to turn them away.

Consequently, we began to operate a job bank for anyone over 55 regardless of income using the guideline that those who are on the Title V program received first priority in help to get jobs.

During the four years of operation, we have had senior aides working in a variety of capacities and in a variety of agencies. Some examples are: respite care aides, clerical aides, drivers for senior centers, social services assistants, administrative assistants, food bank operations, various abuse program aides, information and referral, community mental health workers, day care aides, paralegals, aides for the blind and many more.

Since the inception of the Title V program in Genesee County, we have hired 138 different people to become senior aides. Forty-seven of these aides have been placed into unsubsidized jobs. This represents 34 percent of all senior aides who have been on our program. In addition, we have assisted 137 seniors over 55 to secure unsubsidized jobs.

The fact that we were able to find jobs for that many people in a county which has averaged an unemployment rate of 13.7 percent is something of which I am very proud of.

The Title V program is a very good one for both the older Americans and the community. It provides an opportunity for older adults to remain a productive member of society and contribute positively to the community.

I want to raise several concerns that I have regarding the reauthorization of the Older Americans Act.

The proposed amendment to allow governors of each state to have the final say in where senior aides should be placed is without question a giant step backward for this program. While Michigan is very fortunate in having Governor Blanchard who has been a strong supporter of older Americans, other states are not as fortunate. The national contractors work together with the various states in order to provide coordination and equitable distribution of the positions available. This means that senior aides are distributed by state and county based on the population over 55 and those within 125 percent of the federal poverty guidelines.

Currently Genesee County has 46 positions and 42 percent of these are minority individuals. In July of this year, we will receive an additional 19 positions due to the equitable distribution placement. Genesee County has been grossly under-served in the past.

If the governor had the final word as to where senior aide positions would go throughout the State, it would be possible for him to decide that Wayne County, for example, should get the additional 19 rather than Genesee. I believe that this amendment would raise a very real possibility that positions or slots would be distributed based on politics. I think the old adage of "If it ain't broke, don't fix it" certainly applies in this case.

The second issue is that of, naturally, money. I believe that Title V is the best of two schools of thought. It definitely follows the philosophy of those in government who want people to live in dignity and help themselves, and blends with the President's belief that individuals and state and local government should do everything they can to function with minimum assistance from the federal government. Again, I feel H.R. 1451 would allow just that, as well as continued growth in the Title V program.

Another issue on the reauthorization is that of the unit cost allowed per aide, which is now at $5,111. This cost has remained constant even in the face of older Americans seeing inflation go up, Medicare deductions increase and services dwindle. It is safe to say that the senior aide's wages have actually decreased. While it is not the intent of Title V to make the wages of the older worker so attractive that they stay on the program indefinitely, an increase in unit cost would simply help them attempt to keep their heads above water.

The final issue, Mr. Chairman, is that of the 12 percent administrative cap placed on contractors. The larger contractors, such as NCSC, are able to operate with an efficient program. However, some of the smaller contracts do and will suffer. Indeed, our local area agency on aging is probably hindered by this cap. An increase to 15 percent would allow all contractors to provide continuity of quality services with limited risk of being discontinued as contractors and thereby causing great harm to the older workers who are employed by those sponsors.

Finally, Mr. Chairman, I urge the committee to consider our concerns and recommendations as the committee continues to work on the reauthorization of the Older Americans Act.

Thank you for allowing me the opportunity to speak to you today.

[The prepared statement of Jean M. Blue follows:]

THE TESTIMONY OF JEAN H. BLUE BEFORE THE HOUSE EDUCATION AND LABOR SUBCOMMITTE ON HUMAN RESOURCES UNITED STATES HOUSE OF REPRESENTATIVES. APRIL 10, 1987 FLINT,MI

Mr. Chairman,

My Name is Jean H. Blue. I serve as director of Senior Citizens Services for the Flint Board of Education. I have worked in this capacity for seven years and am responsible for supervision of programs which have positively affected the lives of thousands of senior citizens in our area. I have come to appreciate the great benefit of the partnership between local, state and federal governments along with private enterprise to improve the quality of life for older Americans - the fastest growing population segment in the United States.

We are all pleased, Mr. Chairman, that our very own congressman, who has demonstrated a life-long deep concern and commitment to older citizens, chairs this important committe and, has scheduled this hearing in our district. We are also pleased to have had as a regular participant in our Senior Club Program at Washington School, until her recent incapacitation, the mother of the committe chairman, Mrs. Norma Kildee who, in her genteel manner could provide the committe through its chairman with special positive inputs about our program.

I would like to direct my brief remarks today to one of my areas of responsiblity, the Senior Aide Program which is funded under Title V of the Older Americans Act. I am also here to support passage of H.R. 1451.

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When we started the Senior Aide Program, we had 200 senior citzens 55 and older who applied for 42 jobs. As we were taking applications, I made a decision that if there were that many senior citizens in our community who were looking for and needing jobs, we weren't going to turn them away. Consequently, we began to operate a job bank for anyone over 55 regardless of income using the guideline that those who are on the Title V program received first priority in help to get jobs.

During the four years of operation we have had Senior Aides working in a variety of capacities and in a variety of agencies. Some examples are : respite care aides, clerical aides, drivers for senior centers, social services assistants, administrative assistants, food bank operations, various abuse program aides, information and referral, community mental health workers, day care aides, paralegals, aides for the blind and many more.

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County, we have hired 138 different people to become Senior Aides. 47 of these Aides have been placed into unsubsidized jobs. This represents 34% of all Senior Aides who have been on our program. In addition, we have assisted 137 seniors over 55 to secure unsubsidized jobs.

The fact that we were able to find jobs for that many people in a county which has averaged an unemployment rate of 13.7%, is something I am very proud of.

The Title V program is a very good one for both the Older Americans and the community. It provides an opportunity for older adults to remain a productive member of society and contribute positively to the community.

I want to raise several concerns that I have regarding the reauthorization of the Older Americans Act.

The Proposed amendment to allow governors of each state have the final say in where Senior Aides should be placed is without a question, a giant step backward for this program. While Michigan is very fortunate in having Governor Blanchard who has been a strong supporter of older Americans, other states are not as fortunate. The national contractors work together with the various states in order to provide coordination in equitable distribution of the positions available . This means that Senior Aides are distributed by state and county based on the population over 55 and 125% of the federal poverty guidelines. Currently, Genesee County has 46 positions. In July of this year, we will receive an additional 19 positions due to the equitable distribution placement. Genesee County has been grossly under served in the past. If the Governor had the final word as to where senior aide positions would go throughout the state, it would be possible for him to decide that Wayne County, for example, should get the additional 19 rather than Genesee. I believe that this amendment would raise the very real possibility that positions or slots would be distributed based on politics. I think the old addage of "if it ain't broke, don't fix it" certainly applies in this case.

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Another issue on the reauthorization is that of the unit cost allowed per Aide which is now at $5,111. This cost has remained constant even in the face of older American seeing inflation go up, Medicare deductibles increase and services dwindle. It is safe to say that the Senior Aide's wages have actually decreased. While it is not the intent of Title V to make the wages of the older worker so attractive that they stay on the program indefinitely, an increase in unit cost would simply help them attempt to keep their heads above water.

The final issue, Mr. Chairman, is that of the 10% administrative cap placed on contractors. The larger contractors, such as NCSC, are able to operate an efficient program. However, some of the smaller contractors do and will suffer. Indeed, our local area agency on aging, is probably hindered by this cap. An increase to 15% would allow all contractors to provide continunity of quality services with limited risk of being discontinued as contractors and thereby causing great harm to the older workers who are employed by those sponsors.

Finally, Mr. Chairman, I urge the committee to consider our concerns and recommendations as the committee continues to work on the reauthorization of the Older American Act. Thank you for allowing me the opportunity to speak to you today.

Mr. **Kildee**. Thank you very much.

Mr. Walker?

STATEMENT OF STEVE WALKER, DIRECTOR, SENIOR CITIZEN FOOD PROGRAM, GENESEE COUNTY COMMUNITY ACTION AGENCY

Mr. **Walker**. Good afternoon. My name is Steve Walker, and I am employed by the Genesee County Community Action Agency. And I am the director of Region V's senior nutrition services.

Since our agency piloted the senior food program in Genesee County with the help of a federal demonstration grant in 1973, we have coordinated the implementation of services which have provided nearly 4,500,000 meals to seniors living throughout Genesee, Lapeer and Shiawassee counties.

In September of 1986, the senior food program successfully completed its thirteenth year of providing quality services to area seniors. Older Americans Act funding of $563,000 enabled the program to serve 491,000 meals to over 8,000 seniors. That is one nutritious, well-balanced, hot meal for every $1.15 in Title III C–1 and III C–2 funding spent.

In addition to GLS senior food service programming, GCCAA is providing a wide range of supplementary services to Genesee County's senior population. The employment and development project provides assistance to seniors in the completing of non- continuous household tasks. Project Heat provides weatherization services to the elderly, as well as financial assistance with home heating costs. The neighborhood services center provides transportation for seniors to and from medical appointments and also provides emergency food and clothing to many low income elderly.

In August of 1983 a senior needs assessment survey was completed by the University of Michigan in behalf of the Valley Area Agency on Aging. The Region V survey noted that the top four needs, as ranked by a random sampling of various seniors, was money to live on, poor health, keeping up with the home and loneliness.

Title III C–1 congregate meal programming, as it is currently being provided by our agency and its subcontractors, serves to aid seniors in their efforts to satisfy three of the aforementioned primary needs. For Region V seniors who are concerned about having enough funds to live on, congregate meal programming provides an opportunity to reduce financial liabilities by attending a conveniently located luncheon site and enjoying a nutritious meal at minimal expense.

Area seniors concerned about poor health are assured that each meal received at a congregate site contains a minimum of one-third of the average person's daily dietary needs. Adequately providing for a person's nutritional needs is acknowledged by health care experts as the key element in basic preventative health care.

Finally, the cafeteria atmosphere at the luncheon sites in their neighborhood settings, provide area seniors who suffer from feelings of loneliness an opportunity to renew old acquaintances and to make new ones.

As the principal service provided for by the Older Americans Act, congregate nutrition programming establishes a community focal point for the addressing of social, economic and health needs of the more than 67,000 Region V elderly. By locating congregate sites in area community and senior centers, the applicant agency and its subcontractors have both accessed participating seniors to a host of community resources and facilitated the utilization of those resources by providing them with an effective drawing card.

The role played by Title III C-2, home delivered meals as an integral part of the Older Americans Act in-home service funding is dramatically growing. Though congregate nutrition programming has been targeted as the principal Older Americans Act service, changes in federal Medicaid policies enacted five years ago have generated substantial increases in the demand for mobile meals. Seniors must spend fewer recovery days in the hospital after operations and/or serious illnesses. This places the burden of insuring that a senior safely recovers at home on health care related agencies.

A startling example of this expanding role has been documented by increases in mobile meals served over the same five year period. In 1981, 96,241 meals were served to 658 homebound seniors. In Fiscal Year 1986, 260,609 meals were served to 1,413 seniors. This represents a growth of 271 percent in just five years.

In the coming year the Genesee County Community Action Agency will do its part in behalf of the Older Americans Act programming. We plan to stabilize meal costs for our fifth consecutive year and strive to maintain quality food services. We are also confident that our area seniors will continue to do their part through their continued volunteerism and financial support. You can also trust our local area agency on aging to plan effectively for the utilization of all Older Americans Act funds that are made available for services in our regional area.

It is once again time to call upon our federal legislators to insure that our collective hard work has its reward. The primary goal of the Older Americans Act has been to aid seniors in their efforts to live with dignity and independence in their homes. We believe that senior nutrition services are central to this task, and we trust that in your efforts to secure reauthorization of the act these services will merit your strongest support.

Thank you.

[The prepared statement of Steven Walker follows:]

GCCAA
Genesee County Community Action Agency

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In Conjunction with Valley Area Agency on Aging
Project Director
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April 10, 1987

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In August of 1983, a senior needs assessment survey was completed by the University of Michigan in behalf of the Valley Area Agency on Aging. The Region V survey noted that the top four needs (as ranked by a random sampling of area seniors) were Money to Live On (36.0%), Poor Health (35.0%), Keeping up the Home (19.9%), and Loneliness (18.7%).

Title III C-1 Congregate Meal Programing, as it is currently being provided by our agency and its subcontractors, serves to aid seniors in their efforts to satisfy three of the aforementioned primary needs. For Region V seniors who are concerned about having enough funds to live on, Congregate Meal Programing provides an opportunity to reduce financial liabilities by attending a conveniently located luncheon site and enjoying a nutritious meal at a minimal expense. Area seniors concended about poor health are assured that each meal received at a congregate site contains a minimum of one-third of the averaged person's daily dietary needs. Adequately providing for a person's nutritional needs is acknowledge by health care experts as the key element in basic preventative health care. Finally, the cafeteria atmosphere at the luncheon sites (in their neighborhood settings) provide area seniors who suffer from feelings of loneliness an opportunity to renew old acquaintances and make new ones.

As the prinicipal service provided for by the Older Americans Act, Congregate Nutrition Programing establishes a community focal point for addressing the social, economic, and health needs of the more than 67,000 Region V elderly. By locating congregate sites in area community and senior centers the applicant agency and its subcontractors have both accessed participating seniors to a host of community resources and facilitated the utilization of those resources by providing them with an effective "drawing card".

The role played by Title III C-2 Home Delivered Meals as an integral part of Older Americans Act in-home service funding is dramatically growing. Though Congregate Nutrition Programing has been targeted as the principal Older Americans Act service, changes in federal medicaid policies enacted five years ago have generated substantial increases in the demand for Mobile Meals. Seniors must spend fewer recovery days in the hospital after operations and/or serious illnesses. This places the burden of insuring that a senior safely recovers at home on health care related agencies.

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Mr. Kildee. Thank you very much.

Jean, could you describe the special training project your program has carried out in the area of respite care?

Ms. Blue. Yes, Mr. Congressman.

Two years ago we applied for some extra training monies that our national sponsor has. And we developed a program along with Bay Valley Home Health Care to train 12 persons as respite care aides. Bay Valley did the actual training for us. Each of those individuals completed 90 hours of training whether it was how to deal with older people, bed lifting, transfers, different things like that. And as a result of that, all 12 of those individuals received jobs either in private homes or some of the local area health agencies snapped them up to work on their staff.

And we are currently going to be submitting a grant again this year to do the same thing. Respite care really is a big issue in this area. And it seems as though the older workers—the more we train in that area, they are gone, just like that.

Mr. Kildee. So, you see the need is really there for the respite care.

Ms. Blue. Right.

Mr. Kildee. You have to train. You cannot have everyone go in there who only has goodwill, but maybe not the knowledge.

Ms. Blue. That is correct. And the last thing that anybody wants, certainly when we do that—Flint Community Schools is not the employer in that case. We simply send a person who is looking for a respite care aide a list, and say, you contact them. You do the interview. You are the one that does the hiring.

But that is certainly—it's an issue, and as soon as people become available—we get calls every day from individuals out in the community looking for somebody to come in and not baby-sit, but stay with either their parent or their spouse while they are able to take some time for themselves.

Mr. Kildee. Is there some type of certification program for that? Or is it informal?

Ms. Blue. Well, Bay Valley does give each individual a certificate, and we are looking to work with perhaps maybe our local adult high school to do the same thing and come up with a certificate. Some of the individuals that we have would like to get the longer term certificates, but it takes like two years to get that. And the need is now. So, that is why we have chosen the quicker route.

Mr. Kildee. Steve, an amendment has been proposed to the subcommittee that would permit the use of congregate meal funds for non-nutrition services that may be needed in a program to assist the people, but not allowable under present law. Do you need any more flexibility in your program here in Flint for expending those funds?

Mr. Walker. Well, I have found a great deal of cooperation in working with the area agency on aging to try and adjust to the various demands that have been placed on the program over the last five years. We have seen just dramatic increases in home delivered programming, and if it were not for the area agency's cooperation, I think we would have seen waiting lists in our area a long time ago.

At this point in time we do not have a waiting list. We have not had a waiting list for a number of years. And we have continued to adjust to this problem I think by having an opportunity to experience some transferred funds from time to time in order to make sure that the dollars were going specifically where the needs were in the community.

Mr. **KILDEE**. What was the number of meals on wheels?

Mr. **WALKER**. Well, back—let's see. I was saying that in 1981 we had 658 mobile meal clients that we served over the Region V area. This past year we served over 1,400 clients. And the number of meals that we served increased by 271 percent over that 1981 figure.

Mr. **KILDEE**. Can you pull money from other sources, say, for the transportation cost for the delivery of the meals? Or do you have enough flexibility to take it from the nutrition service part?

Mr. **WALKER**. We have had enough flexibility to take it through the nutritional funds. We have actually been quite successful in our area in still maintaining a staff of people to route the meals out to the seniors. And from what I understand from a variety—while having an opportunity to talk with a variety of the other directors in the State of Michigan, this is kind of a vanishing way of doing the job. We are still maintaining Monday through Friday service. We have a person out to the person's home to see that individual, to the senior face to face on a daily basis. And we believe that that is really important. We are sometimes the first person on the scene when that senior is having some difficulty.

At present we have still been able to utilize our funding, to manage our funding, along with the help of the area agency, so as to enable us to take care of that need without touching on outside funds.

Mr. **KILDEE**. My mother, who lives alone, receives a meal and she pays for it. But I tell you, it is a great solace to her to know that someone is going be knocking on her door every day, and that she's got that nutritious meal.

What happens very often and I have seen it with my own mother is that you come home from the hospital, as she did. You do not feel very good in the first place, so you do not cook a good meal. Then you get sicker, and you feel worse. But with a nutritious meal there is a chance of at least getting those people back to where they are feeling better. The fact that they knock on her door every day is a great source of comfort to her too.

Now, you said that this is the way it operates here. What modality do they use in other places?

Mr. **WALKER**. Well, there are some areas, in their efforts to try and insure that people who are qualified for services receive those services, you know, to avoid waiting lists—in some cases the meals might be routed on a weekly basis, maybe on a Monday all the meals will be delivered. Frozen meals might be delivered for a week. And then the person will go back and make a delivery then again next week. Or there are some sets of circumstances where there is kind of intermittent service where the person might go out on Mondays, Wednesdays and Fridays instead of on a Monday through Friday basis.

We have managed to avoid that at this point. In fact, in the Lapeer County area the funding—they have been able to utilize their funding out there to even provide kind of an emergency weekend meal pack in addition to the Monday through Friday service. We have been very fortunate at this point in time, but I think that is due to a lot of advanced planning, a lot of senior support with respect to their donations in behalf of the services, and then, as I have mentioned, on several occasions the flexibility of our area agency.

Mr. **Kildee**. Those are two things that I want to try to help you continue. It is an excellent method. If you can supply any material to this committee, we will make it part of the record so we can share it with other people throughout the country, where perhaps it can be replicated.

Mr. **Walker**. Sure.

Mr. **Kildee**. This is an ideal method because it not only gives nutrition, but gives an opportunity to remove some isolation by checking in on the person. I commend you for having retained this method. And if you could supply us any material you have on it, we would like to have that as part of the record for this hearing.

Mr. Sawyer?

Mr. **Sawyer**. Thank you, Mr. Chairman.

With the flexibility to use those dollars in creative and constructive ways, there probably is also the latitude to use those dollars in ways for non-nutritional purposes that while creative, might not be so beneficial.

Where do we draw the line? How do we prescribe the limits for that increased flexibility? Do you see what I am getting at?

Mr. **Walker**. Yes, I think so. I know in having an opportunity to talk with nutrition directors, say, outside of my area, that there is a great concern as to the Title III C-1 dollars and III C-2 dollars staying within senior nutrition programming.

Mr. **Sawyer**. However worthwhile those other uses might be.

Mr. **Walker**. Exactly. I can only speak for our area in the sense of saying that the demands on our program have been pretty dramatic over the last few years. And it has been quite easy for us to go into the area agency and document that there is a clear reason for utilizing all Title III C-1 and III C-2 dollars within the area of senior nutrition programming.

There has also been I think a strong effort on our parts over the last few years to resist the desire to be greedy and go after IIIB dollars as well. We have chosen I think instead to really work with our seniors, the seniors that we are serving in terms of educating them about the need to donate, how that money is utilized, what kinds of services we are going to be able to provide if there is strong community support, strong volunteerism, strong financial support of the programming. So, I guess we have managed to circumvent some of the difficulty that perhaps has been experienced elsewhere in fighting over those dollars to determine exactly where they are going to get spent.

Mr. **Sawyer**. Good people in a common purpose.

Mr. **Walker**. Yes. I feel pretty comfortable with that idea. I think that there is kind of a need probably on a national level to make sure that dollars are specifically earmarked to insure that when people are not working together with a common purpose that the seniors are definitely taken care of in the long run. But for us to have that flexibility, it has made our program grow. I don't think without that flexibility we would have been able to take care of the numbers of people that we have over the last few years.

Mr. **Sawyer**. I guess the thing we are going to have to struggle with is where you put the limits on the stretch.

Mr. **Walker**. Yes.

Mr. **Sawyer**. You have talked about the kinds of placements that you have, particularly in your training program. What kinds of jobs have you been most successful in placing folks in?

Ms. **Blue**. I assume you are referring to unsubsidized jobs?

Mr. **Sawyer**. Right. I come from a county which has employment not as high as your own. And we could learn from your success.

Ms. **Blue**. It has been everything from clerical to some of our host agencies have enjoyed the senior aide that has been working with them for two years so much to the point that they put them on their payroll. Certainly some of the host agencies, such as our local food bank—we had on our staff an excellent job developer. And I knew he was not going to stay there long because of his skills and the food bank took him from us.

We have placed persons in city government, in county government. One of the calls that we received recently was from one of the local hardware building supply stores that was looking for part-time people. And they consequently hired three retirees. Some of the area nursing homes were just starting to be able to have the private employers, small businesses out there, recognize the fact that they can call us. They can give us what they are looking for. We don't charge any fee, and we will be happy to work with them.

It has been a struggle here and across the country to try to dispel the myth that older workers are non-productive. But basically just about any type of job that you would imagine we have had a pretty good success in placing them.

Mr. **Sawyer**. Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you, Mr. Sawyer.

Michigan is a state that in general takes money in lieu of commodities. But you use commodities from the Agriculture Department in your program?

Mr. **Walker**. We have access to some commodities. I believe cheese and powdered milk, and I think peanut butter for a while. There are a few commodities that we have access to.

Mr. **Kildee**. The slower moving ones.

Mr. **Walker**. Right, right, exactly.

We are receiving cash reimbursement currently, as you are aware.

Mr. **Kildee**. Michigan is a cash in lieu of commodities state. You probably are able to get some of the excess, excess commodity then.

Mr. **Walker**. Right, right.

To touch on the idea of the cash reimbursement, I know that there has been some talk at the federal level, and as far as taking a look at perhaps instead of going on a per meal reimbursement basis to a fixed amount, we are really concerned about that because in our particular area where we have been able to have the financial resources come together to enable us to serve perhaps quite a few more meals than we would have otherwise, if that becomes a fixed figure, of course, the dollars are going to run out a lot faster than what we are currently experiencing.

Mr. **Kildee**. A fixed figure would be for the previous year. It would put a chilling effect on expansion of a program, would it not?

Mr. **Walker**. That is correct.

Mr. **Kildee**. You see more people pulling into the parking lot, and say, good heavens, can we handle it? Right?

Mr. **Walker**. That is right.

Mr. **Kildee**. That was my thought when I read the proposal. It would take the previous year, and you would have almost a disincentive to try to expand the program.

Mr. **Walker**. That is right. See, we served 260,000 home delivered meals plus last year. This year we are going to serve 300,000. And if we were not able to receive the reimbursement on a per meal basis, then we would lose out on 40,000 meals. And 40,000 times 50 cents, well, that is $24,000. So, it is going to create a real problem for our programming.

Mr. **Kildee**. About a year ago, I think we worked with Libby Maynard to get both the authorization raised and the appropriation. We worked so fast, I think one got ahead of the other. But we finally got the money. [Laughter.]

Mr. **Kildee**. I feel personally proud of what we have seen here today. I think we have seen two model programs through the two people right here: the respite care training, which I think is going to be a growing area, and the way you deliver these meals on wheels. I am very proud of that. I really very much appreciate your testimony—both of you.

Mr. **Walker**. Thank you.

Ms. **Blue**. Thank you.

Mr. **Kildee**. Our next panel consists of Phyllis Byrd, Assistance Director, Shiawassee County Council on Aging; and John Crews, Senior Blind Program, Michigan Department of Labor; Danice Chisholm, Executive Director, Caregivers; and John Peterson, Division Director of Program Development, Advocacy and Planning will read the testimony of Mr. Al Rightley.

Mr. Peterson, we will let you lead off with that testimony.

STATEMENT OF JOHN PETERSON, DIVISION DIRECTOR OF PROGRAM DEVELOPMENT, ADVOCACY AND PLANNING, MICHIGAN COMMISSION ON SERVICES TO THE AGING

Mr. **Peterson**. Thank you very much. I have a dual honor. One is appearing as a member of your panel, and the other is representing Al Rightley, who is the chairperson of the Michigan Commission on Services to the Aging. And Al wanted to extend his welcome to you and his gratitude for you convening this panel on the Older Americans Act. It is a very important act, as you have gathered already from your testimony here today, to all of us in Michigan and particularly to Commissioner Rightley.

It has been instrumental particularly in addressing the needs of older citizens within Michigan. It has been a catalyst. It has been a piece of legislation that since 1965 has given us a very important sense of direction.

In the 1970's the Older Americans Act began to give hope to our frail elderly citizens here in Michigan whose only previous alternative, when they reached the time when they needed support, was to go into a nursing home.

In the 1980's these in-home services that became the real sense of direction that the Older Americans Act gave to us here in Michigan further expanded as we saw an increase, as you have just heard, in home delivered meals, various levels of in-home care services, respite care, and such alternative care services as adult day care.

The need for these services has increased even though the resources for in-home care in Michigan has also increased. As you are well aware being from Michigan, the Michigan legislature has picked up its responsibility. The governor of Michigan has picked up his responsibility with regard to the growth of alternative care services.

In spite of all this and increasing state appropriations to in-home care services in the State of Michigan, the need for these services is just simply—the need is greater and it far exceeds both federal and state resources that we have to apply to this. So, we welcome the direction that you are giving this particular reauthorization in focusing again on in-home services. We certainly think that is very, very important. The elderly of Michigan, as the elderly of the nation, is struggling to maintain their independence. And oftentimes the difference in being able to successfully maintain independence is the services provided under the Older Americans Act here in Michigan through the governor and the state legislature under the Older Michiganians Act.

The aging network has had to take many actions to insure that services are targeted for those people who are most in need. The Commission on Services to the Aging here in the state has approved comprehensive service standards to insure quality, an ongoing concern of us in the in-home service arena, and to require in-home assessments of folks applying for these services so that the agencies can be assisted in determining and prioritizing the need of a given client. Ongoing assessment is also a part of our program here in Michigan.

We have waiting lists for in-home services. We also have experienced in the last few years service providers having to cut the amount of service that a particular client gets so that other clients' needs can be met. Typically a person who may need services four or five times during a week will only get services one or two times during a week so that others can get services one or two times a week also. This is a very pressing statement of our need situation.

The Older Americans Act, whose purpose is to provide the assistance needed to older persons so that they can live independently, should continue to maintain in-home services as a priority.

Commissioner Rightley also wanted to stress what you have heard from us earlier, and that is, it is absolutely essential that this reauthorized act include the creation of your Title III, part D, so that we can have the necessary additional resources to address in-home services particularly to the frail elderly.

We want to end by thanking you again for convening this hearing here in Flint so that we in Michigan, and particularly the Commission on Services to the Aging in Michigan, together with the office, can present particularly our needs for our citizens. We look forward to continuing and strengthening the network of services that has been created through the Older Americans Act to promote the independence of our older citizens.

Thank you very much, Congressman.

[The prepared statement of Joseph A. Rightley follows:]

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STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
OFFICE OF SERVICES TO THE AGING
OLIVIA P. MAYNARD, Director

COMMISSION
JOSEPH A. RIGHTLEY
CHAIRPERSON

TESTIMONY BEFORE THE HUMAN RESOURCES SUBCOMMITTEE OF THE U.S. HOUSE OF REPRESENTATIVES

APRIL 11, 1987

I AM AL RIGHTLEY, CHAIRPERSON OF THE MICHIGAN COMMISSION ON SERVICES TO THE AGING. THE COMMISSION THANKS YOU FOR BRINGING THIS PUBLIC HEARING ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT TO MICHIGAN. IT GIVES US THE OPPORTUNITY TO TELL YOU DIRECTLY ABOUT THE IMPORTANCE OF THIS LEGISLATION TO THE OLDER CITIZENS OF THE STATE.

THE OLDER AMERICANS ACT HAS BEEN INSTRUMENTAL IN ADDRESSING THE NEEDS OF OLDER CITIZENS WITHIN MICHIGAN. THIS IS ESPECIALLY TRUE REGARDING THE DEVELOPMENT OF SERVICES THAT PROVIDE ALTERNATIVES TO INSTITUTIONALIZATION FOR OLDER PEOPLE UNABLE TO LIVE IN THEIR OWN HOMES WITHOUT ASSISTANCE. IN THE 1970'S, THE DEVELOPMENT OF IN-HOME SERVICES PROVIDED THROUGH THE OLDER AMERICANS ACT BEGAN TO GIVE HOPE TO FRAIL ELDERLY WHOSE ONLY PREVIOUS ALTERNATIVE WAS PLACEMENT INTO A NURSING HOME. IN THE EARLY 1980'S SERVICES CONTINUED TO BE DEVELOPED AND HAVE GROWN TO INCLUDE HOME DELIVERED MEALS, VARIOUS LEVELS OF IN-HOME CARE SERVICES, RESPITE CARE AND ALTERNATIVE CARE SUCH AS ADULT DAY CARE SERVICES. DURING THE TIME THAT THESE SERVICES HAVE GROWN, THE DEMAND FOR THEM HAS ALSO GROWN. MOST

SERVICE PROVIDERS EXPERIENCE SOME FORM OF WAITING LIST FOR THE VARIOUS IN-HOME SERVICES THEY ARE PROVIDING. THERE ARE CURRENTLY OVER 3000 PEOPLE ON THE WAITING LIST FOR HOME DELIVERED MEALS AND 2000 PEOPLE FOR HOME CARE.

THE NEED FOR SUCH SERVICES HAS INCREASED EVEN THOUGH RESOURCES FOR IN-HOME CARE IN MICHIGAN HAS ALSO INCREASED. CURRENTLY AAA'S ALLOCATE 25% OF THEIR III-B DOLLARS TO IN-HOME SERVICES. ADDITIONALLY, TRANSFERS FROM CONGREGATE TO HOME DELIVERED MEALS HAVE INCREASED 22.9% FROM 1984 TO 1986. THE STATE LEGISLATURE HAS ALSO RECOGNIZED THE INCREASING NEED FOR ALTERNATIVE CARE SERVICES AND HAS MADE SPECIAL ALLOCATIONS TO SUPPLEMENT FUNDING FOR THE OLDER AMERICANS ACT SINCE 1982. THESE ALLOCATIONS HAVE STEADILY INCREASED. IN 1982, 1.8 MILLION DOLLARS WAS ALLOCATED FOR ALTERNATIVE CARE AND 2.9 MILLION DOLLARS FOR HOME DELIVERED MEALS. IN 1987, 5.4 MILLION DOLLARS WAS ALLOCATED TO ALTERNATIVE CARE, INCREASING FROM 1982 BY 197%. HOME DELIVERED MEALS WAS INCREASED TO 5.3 MILLION DOLLARS, AN 80% INCREASE.

AND YET THESE FUNDS ONLY BEGIN TO MEET THE NEED FOR THOSE ELDERLY STRUGGLING TO MAINTAIN THEIR INDEPENDENCE. THE AGING NETWORK HAS HAD TO TAKE MANY ACTIONS TO ENSURE THAT SERVICES HAVE BEEN TARGETED TO THOSE PEOPLE MOST IN NEED. THE COMMISSION HAS APPROVED COMPREHENSIVE SERVICE STANDARDS TO ENSURE QUALITY AND TO REQUIRE IN-HOME ASSESSMENTS THAT ASSIST THE AGENCY IN DETERMINING AND PRIORITIZING THE NEED OF THE CLIENT. ON-GOING REASSESSMENTS ARE ALSO REQUIRED TO ENSURE THAT THOSE RECEIVING THE SERVICE CONTINUE TO NEED THE SERVICE. SERVICE PROVIDERS ARE REQUIRED TO DETERMINE ELIGIBILITY FOR SERVICES AVAILABLE THROUGH TITLE XX OF THE SOCIAL SECURITY ACT TO ENSURE COORDINATION WITH OTHER RESOURCES AVAILABLE FOR SERVICES.

EVEN WITH OUR EFFORTS TO TARGET SERVICE AND MEET THE NEEDS OF OUR ELDERLY CITIZENS, SERVICE PROVIDERS ARE OFTEN FACED WITH CUTTING THE AMOUNT OF SERVICE A CLIENT NEEDS SO THAT OTHER CLIENTS' NEEDS CAN BE MET. SUCH ACTIONS CREATE PROBLEMS REGARDING THE EFFECTIVENESS OF A SERVICE IF IT CAN NOT BE PROVIDED AT THE LEVEL NEEDED.

AS THE AGING POPULATION CONTINUES TO GROW, WE CAN EXPECT THAT THE NEED FOR IN-HOME SERVICES AND ALTERNATIVES TO INSTITUTIONALIZATION WILL CONTINUE TO INCREASE. THE OLDER AMERICANS ACT, WHOSE PURPOSE IS TO PROVIDE THE ASSISTANCE NEEDED TO OLDER PERSONS SO THEY MAY LIVE INDEPENDENTLY, SHOULD CONTINUE TO MAINTAIN IN-HOME SERVICES AS A PRIORITY. THE STATE ALSO SUPPORTS THE CREATION OF A TITLE III PART D FOR IN-HOME CARE SERVICES TO SUPPLEMENT FUNDS WHICH ARE ALLOCATED TO IN-HOME SERVICES THROUGH PART B. IT IS OUR UNDERSTANDING THAT THE PROPOSED PART D SERVICES WILL BE TARGETED TO FRAIL ELDERLY AND WILL BE COORDINATED WITH OTHER SERVICE PROGRAMS SO THAT THE FUNDS WILL BE USED WHEN NO OTHER RESOURCES ARE AVAILABLE. THE CREATION OF PART D WILL ALLOW THE AGING NETWORK TO ENSURE THAT THE "OLDER" AGING POPULATION, THE FASTEST GROWING SEGMENT OF THE ELDERLY POPULATION, WILL RECEIVE THE ASSISTANCE THEY NEED TO REMAIN INDEPENDENT.

AGAIN, THANK YOU FOR PROVIDING US THE OPPORTUNITY TO EXPRESS OUR VIEWS REGARDING THE REAUTHORIZATION OF THE OLDER AMERICANS ACT. WE LOOK FORWARD TO CONTINUING AND STRENGTHENING THE NETWORK OF SERVICES THAT HAS BEEN CREATED THROUGH THIS ACT TO PROMOTE THE INDEPENDENCE OF OUR OLDER CITIZENS.

Mr. **Kildee**. Thank you very much.

Phyllis? Phyllis Byrd?

STATEMENT OF PHYLLIS BYRD, ASSISTANT DIRECTOR, SHIAWASSEE COUNTY COUNCIL ON AGING

Ms. **Byrd**. I would like to say good afternoon, and thank each of you for giving us the opportunity to be heard here today. And I would like to say hi to you. I have not seen you for a long time.

Mr. **Kildee**. I caught your eye a little while ago. It has been a long time.

Ms. **Byrd**. Well, I was living out of the state for a few years.

Mr. **Kildee**. Good to see you again.

Ms. **Byrd**. It is nice to see you again.

We did this quite hurriedly from being called Wednesday afternoon or Thursday afternoon, so I hope we covered the most important points.

The Shiawassee Council on Aging board of directors and staff on behalf of the senior residents of Shiawassee County wishes to submit testimony in support of needed services to assist homebound isolated elderly and frail elderly citizens to remain in independent living situations that foster their continued wellbeing.

Currently in Shiawassee County we have approximately 62 to 70 persons receiving personal care or homemaking services or a combination of the two at a cost of approximately $70,000 per year. At $60 per day for nursing home care per individual, if half of our clients were to enter basic care nursing homes, the cost for their care would be approximately $766,000 per year, or twice that figure for all 62 to 70 clients. In terms of cost benefit considerations, in-home services remain the most viable option for assisting this vulnerable group of individuals on a day-to-day basis at roughly one-tenth the cost of institutional care.

In our rural area where population centers are few, with the largest being approximately 16,000 persons, human services resources are much more limited than in urban areas, and must be stretched to their limits.

Of the group of persons 65 and older in Shiawassee County, almost one-third have incomes of less than $350 per month for all needs, and of that group approximately 70 percent are women. Progressing along the age scale, individuals 75 and over in this area are typically women living alone, low income and often socially isolated due to lack of transportation, lack of family support systems, lack of mobility and other factors.

While these same factors are present within this age group in urban settings, distance from service and resources and overall lack of services/resources does not present the difficulties faced by the rural elderly.

Assisting this group through giving baths, shampoos, shaves and other normal activities and/or providing light housekeeping chores, shopping, banking, medical appointments and social contacts, such as an occasional visit to the local senior center to see an old friend or a short trip to K Mart for personal items and lunch, enhances self-esteem provides vital stimulation and contributes to the overall wellbeing of the elderly client.

As our population ages in greater numbers, services such as these will continue to be the most viable alternative to institutionalized care as well as demonstrating our commitment to the principal that we value our older citizens.

In addition to the figures that I mentioned earlier, while I was listening to the testimony here, I figured out—and I didn't have a calculator—that there are 1,440 minutes in a 24 hour day. There are 525,600 minutes in a year, times $70,000, would come to $36,792,000,000. And I don't think that that figure would even approach the total outlay of our countries budget and/or any part of its deficit. So, what I am saying is that the $70,000 a year to assist these individuals—much more than that is spent every minute of the day on the debt—I mean on the interest for the national debt.

[The prepared statement of Phyllis Byrd follows:]

Shiawassee Council on Aging, Inc.
ADMINISTRATIVE OFFICES
300 N. WASHINGTON STREET
OWOSSO MICHIGAN 48867-2823

The Honorable Dale E. Kildee
United States Representative - 7th District

In-Home Services for the Rural Elderly

Representative Kildee and Panel Members:

The Shiawassee Council on Aging Board of Directors and staff, on behalf of the senior residents of Shiawassee County, wishes to submit testimony in support of needed services to assist homebound, isolated elderly and frail elderly citizens to remain in independent living situations that foster their continued well-being.

Currently in Shiawassee County, we have approximately 62-70 persons receiving Personal Care or Homemaker services or a combination of the two at a cost of approximately $70,000 per year. At $60 per day for nursing home care, if half of our clients were to enter basic care nursing homes, the cost for their care would be approximately $766,000 per year, or twice that figure for all 62-70 clients. In terms of cost-benefit considerations, in-home services remain the most viable option for assisting this vulnerable group of individuals on a day-to-day basis at roughly one-tenth the cost of institutional care.

In our rural area where population centers are few, with the largest being approximately 16,000 persons, human services resources are much more limited than in urban areas and must be stretched to their limits. Of the group of persons age 65 and older in Shiawassee County, almost one-third have incomes of less than $350 per month for all needs and, of that group, approximately 70% are women. Progressing along the age scale, individuals 75 and over in this area are typically women, living alone, low-income and often socially isolated due to lack of transportation, lack of family support systems, lack of mobility and other factors. While these same factors are present within this age group in urban settings, distance from services/resources and overall lack of services/resources does not present the difficulties faced by the rural elderly.

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– TELEPHONES –
OWOSSO SENIOR CENTER (517) 723-8875 ● IN HOME SERVICES (517) 723-8877 ● DURAND AREA CENTER (517) 288-4122
AN EQUAL OPPORTUNITY EMPLOYER ● FUNDED IN PART BY VALLEY AREA AGENCY ON AGING

local senior center, to see an old friend or a short trip to K-Mart's for personal items and lunch enhances self-esteem, provides vital stimulation and contributes to the over-all well being of the elderly client.

As our population ages in greater numbers, services such as these will continue to be the most viable alternative to institutionalized care, as well as demonstrating our commitment to the principal that we value our older citizens.

Thank you.

Respectfully submitted,

Phyllis Byrd

Robert Bluedorn, Director

Phyllis Byrd, Assistant Director

Mr. **Kildee**. I would guess too that while we have been sitting here today the Pentagon has spent more money than we will spend all next year for Older Americans Act, right close to it anyway, just as an aside. I don't have my calculator either, but——

[Laughter.]

Ms. **Byrd**. Well, I am a little shaky on this because I was doing it by hand. But I am sure I put the decimal in the right place.

Mr. **Kildee**. That is always my problem.

Are you finished with your testimony at this point?

Ms. **Byrd**. Yes.

Mr. **Kildee**. Thank you very much, Phyllis. I appreciate it. Good to see you again, too.

John Crews. Good to see you again, John.

STATEMENT OF JOHN CREWS, SENIOR BLIND PROGRAM, MICHIGAN DEPARTMENT OF LABOR

Mr. **Crews**. My name is John Crews. I am program manager with the Michigan Commission for the Blind and I supervise programs for the elderly blind. And I might add, until recently I served as vice president of the board of the Midland County Council on Aging, so I know the aging network pretty well.

I want to express to you my thanks for inviting me here today, and I want to express my appreciation for holding hearings on reauthorization of the Older Americans Act here in Flint. You are bringing government to the people, and that action speaks to your commitment to the older citizens of Michigan and this country.

I want to talk to you very briefly about older people who are or become blind. While we know that many older people continue to live vigorous productive lives well into their 70s and 80s, we know that many older people experience disability. And that is an intense and pervasive reality. Dr. T. Franklin Williams, the Director of the National Institute on Aging, reminds us that two out of three older people will die as a disabled person.

I want to speak to a very important segment of the old and disabled population. Four of the five leading causes of blindness are age related. Nearly 70 percent of the blind population are over the age of 60, and for people age 85, one person in five experiences severe vision impairment.

The National Eye Institute estimates that there are 4.5 million older people in this country who are legally blind. But as with most issues that relate to the graying of America, the number of older blind citizens too will be increasing dramatically. We estimate, for example, that the number of blind people over age 75 will increase by nearly 50 percent in the next two decades.

While we know that five percent of the older population reside in nursing homes or similar institutions, available data suggests that 17 to 20 percent of older blind people are institutionalized. The economic costs are staggering. Last year alone, for example, individuals in the government paid over $4.9 billion to institutionalize older blind citizens.

We simply do not know to what degree blindness is a risk factor leading to institutionalization, but these data suggest that it is a great factor, indeed. Unchecked, these costs will soar to $9.5 billion without adjusting for inflation by the year 2020.

We know that besides the great economic costs, there are great and untold social costs of blindness as families struggle virtually alone to attend to the needs of aging parents and spouses. Daughters and daughters-in-law may quit jobs to take care of older blind parents, and older men and women are forced to change roles as women must learn to deal with the outside world and men must learn to nurture. As the nation ages, children in their 60s care for parents in their 80s, and we are forced into roles for which we are neither prepared nor rehearsed.

We as a nation have forgotten the needs of older people with severe vision impairment. We often wrongly assume that there are existing programs for these people or worse yet, we blame the victim and are willing to accept the loss of vision as an inevitable fact of aging. And we too willingly accept and promote the loss of productivity of older blind people.

With appropriate rehabilitation services older blind citizens can often continue to perform most activities of daily living. They can learn travel skills, meal preparation skills and communication methods that allow them to lead productive, independent lives. But for most older blind people, rehabilitation is simply not an available option.

There are in this country more older blind people than there are older people with Alzheimer's disease. Yet, aging and blindness has simply not become an issue on the public policy agenda.

As you consider legislation to reauthorize the Older Americans Act, I would like to make the following suggestions. One, that legislation encourage state and regional planning bodies to better assess the needs of older blind people, especially by asking functional questions about vision capability. This will create an important data base that will foster better planning.

Two, that the needs of the older blind be specifically included in targeting services.

Three, that the linkages between state and local blindness agencies and the aging network be encouraged.

And four, that existing and proposed legislation be written to include rehabilitation services as a permissible expenditures.

Mr. Kildee, Mr. Sawyer, I appreciate your time today. Thank you very much.

[The prepared statement of John E. Crews follows:]

The Rehabilitation Continuum
for Older Blind People

Testimony Prepared for the
U. S. House of Representatives
Subcommittee on Human Resources
for
Reauthorization of the Older American Act
April 27, 1987

Prepared By

John E. Crews
Program Manager
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411-G East Genesee
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Introduction

As we consider reauthorization of the Older American's Act, I believe that we must give consideration to the needs of older people who are or become blind. While we know that many people lead vigorous, productive lives well into their seventies and eighties, we know that for many older people disability is an intense and pervasive reality. Dr. T. Franklin Williams, the Director of the National Institute on Aging, reminds us that two out of three individuals will die as a disabled person.

Demographic Forces

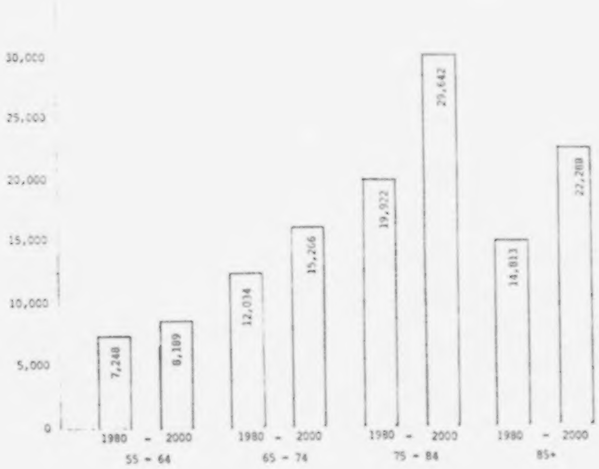
Older people who are blind represent an important segment of the older disabled population. No discussion of the issue of aging and blindness can ignore the demographic realities facing this nation. Four of the five leading causes of blindness are age related. Nearly 70% of the blind population are over the age of 60, and for people over age 85, nearly one person in five experiences severe vision impairment.

As the general aging population increases, and especially as growth occurs among the older old (those over 75), significant increases will occur in the blind population. Although accurate data are difficult to obtain, a 1985 House Select Committee on Aging report asserts that "Nearly one out of every six Americans age 65 or older is blind or severely visually impaired--a group totalling 4.5 million" (U.S. House of Representatives, 1985). In Michigan, nearly 47,000 residents over age 65 do not have sufficient vision to read a newspaper, and over 23,000 are legally blind. We expect the number of blind citizens over age 75 to increase by 50% in the next two decades. Most of these citizens, we must remember, grew up, worked, reared their families, and retired as sighted people; they were unable to take advantage of rehabilitation resources available to younger people. Because of these increases in the numbers of older blind individuals, greater demands will be placed upon the family and public institutions in the coming decades.

In addition, blindness among the elderly is inextricably involved with other social issues. Older blind people are poorer and more likely to be multiply impaired than the general older population. They are more likely to be women, and they are more likely to be minorities than the general population. Elderly blind living in rural areas have enormous problems with transportation and access to service, and urban blind often fear of being victims of crime. These problems are as complex and dynamic as any social policy issue before us.

The increases in the numbers of older blind is displayed in Table I below. The greatest increases will be among the older old (those of 75) who often experience diminished health.

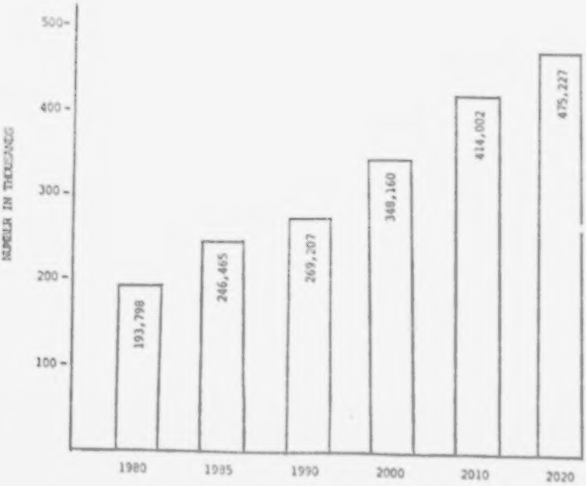
Number of Severely Impaired Seniors
Projected: Michigan 1980 - 2000



Age	NCHS Prevalence per 1000	Number of SVI 1980	Number of SVI 2000	% Increase
55-64	7.8	7,248	8,189	12.9%
65-74	22.3	12,034	15,266	26.9%
75-84	64.9	19,922	29,642	48.8%
85+	181.5	14,813	22,288	50.4%

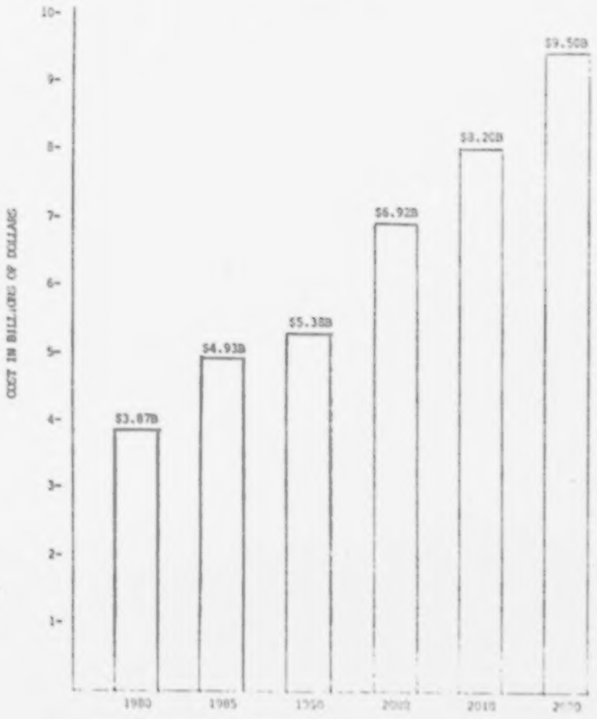
Available data suggest that older visually impaired individuals are at a much greater risk of institutionalization than those who are sighted. While 5% of the general older population reside in nursing homes or skilled care facilities, nearly 20% of those who are older and blind live in nursing homes. Demands for this level of care will increase as the general population ages. Table II demonstrates the increases in the numbers of those who are older and blind residing in institutions.

Institutionalized Older Visually
Impaired Population Projections: United States
1980 - 2020



The economic costs of institutionalizing older blind people are staggering. In Michigan, the annual cost is $88,000,000; nationally, the cost exceeds $4.9 billion. These costs, too, will increase as the general population ages. Table III illustrates these increasing costs. Since most older people exhaust personal resources within four months of being institutionalized, these costs are borne by public funds.

Cost of Institutionalization of
Severely Visually Impaired Older Individuals
United States
1980 - 2020



*Cost not adjusted for inflation

Independent Living

Until recently, perhaps, we have underestimated the value of independent living as an appropriate rehabilitation goal. Traditional rehabilitation models have focused upon younger people and employment opportunities; independent living was often viewed as a step to reach vocational objectives. While these are worthy goals, the emphasis has tended to exclude older blind people. The independent living movement in this country has often defined independent living as maximizing opportunities for self direction; we believe this concept applies equally to younger and older people. Yet Sidney Katz points to a more fundamental principle; he writes, "Instead of death, the end point of life expectancy is the loss of independence in the activities of daily living" (Katz, et. al, 1983). Independent living, therefore, in our view, should be championed as a valuable goal in and of itself. The Michigan Commission for the Blind has operated programs for the older blind for over seven years, and we are beginning to understand the remarkably complex issue of aging rehabilitation.

Small Gains

Early on in our efforts to serve older blind people, we tended to assert the miracles we were able to perform. We related ancedotes about isolated people who became productive and involved; while these incidents were important, these situations did not represent typical clients. Most of our efforts were characterized by helping people learn to cook, cross streets, shop independently, or read some printed materials. T. Franklin Williams uses the term "small gains" to capture this concept; he writes, "Another major consideration in the rehabilitative approach to elderly persons is the importance of what may seem to be small gains in function. Such 'small gains' can make all the difference in the degree of independence that a person can achieve, including the difference between being able to live in one's own home and requiring care in a long-term care institution" (Williams, 1984). Williams uses the example of transferring from wheelchair to chair, bed, or commode. Our experience with communication and travel skills are no less powerful.

Our interest in this small gains concept as well as independent living has influenced our development of functional assessment tools that measure independent living skills and small gains made in functional ability.

Impact on the Family

Amy Horowitz begins a 1985 article by observing, "Over the past several years we have witnessed an explosion of professional and scholarly interest in family relationships of older people and in the implications of these relationships for both the care of the frail elderly and the well-being of their caregiving families" (Horowitz, 1985). While these issues have gained increased attention, virtually nothing has been written about the families of older blind people, and rehabilitation activities have rarely focused upon the needs of the older blind person and the needs of the family.

Stanley Brody and others have observed tht 80% of the caregiving of disabled elderly is provided by family, contrary to the popular myth that older people are abandoned by their families (Brody, 1978). Ethel Shanus notes that the role of caregiving generally falls to the spouse, and if no spouse is available, to the daughter or daughter-in-law (Shanus, 1979). And Elaine Brody has spoken of the woman-in-the-middle, to characterize the role that some women experience in attempting to take care of their children and disabled parents (Brody, E., 1985). Stanley Brody concludes, "The presence of the family and its availability as a source are salient factors in delaying, if not preventing, institutionalization of the chronically ill older person" (Brody, S., 1978).

Horowitz's survey of caregiving literature reveals that the family provides support in four areas: emotional support (social interaction and "'Cheering up'"), direct service provision (shopping, transportation, meal preparation, personal care), mediation with organizations (serving as buffer to bureacracies), and financial assistance (Horowitz, 1985). Horowitz, also notes that because of the demands of providing support, caregivers experience considerable stress, most neglect other family responsibilities, and must often give up employment. The social and economic impacts are just beginning to be measured.

We believe that one of the emerging issues we must address in blind rehabilitation and independent living is developing strategies to better serve blind people and their families. We recognize the complexity and dynamic quality of these issues.

Michigan's Program Models

Public Act 260 of 1978 mandated independent living for older and multiply-disabled blind. Since 1980, the Commission has established four programs to begin meeting the needs of this emerging population. While each project has a specific goal, they are all being merged into the Commission's Independent Living Rehabilitation Program.

Services include information and referral, skills training in communication, activities of daily living, and travel, advocacy, case management, low vision, hearing, and peer support.

With appropriate rehabilitation services, older blind citizens can often continue to perform most activities of daily living. They can learn travel skills, meal preparation skills, and communication methods that allow them to lead productive, independent lives. But for most older blind people, rehabilitation is simply not an available option.

Conclusion

We as a nation have forgotten the needs of older people with severe vision impairment. We often wrongly assume that there are existing programs for these people, or worse yet, we blame the victim, and are willing to accept the loss of vision as an inevitable fact of aging, and we too willingly accept and promote the loss of productivity of older blind people.

There are in this country more older blind people than there are older people with Alzheimer's disease. Yet aging and blindness have simply not become an issue on the public policy agenda.

As you consider legislation to reauthorize the Older American Act, I would like to make the following suggestions:

1. That legislation encourages state and regional planning bodies to better assess the needs of older blind people--especially by asking functional questions about vision capability. This will create an important database that will foster better planning.

2. That the needs of older blind be specifically included in targeting services.

3. That linkage between state and local blindness agencies and the aging network be encouraged, and

4. That existing and proposed legislation be written to include rehabilitation services as a permissable expenditure.

I appreciate the opportunity to submit this testimony to the House Subcommittee on Human Resources.

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Mr. KILDEE. Thank you very much, Mr. Crews.

Our last witness in this panel is Danice Chisholm, Executive Director of CareGivers.

STATEMENT OF DANICE CHISHOLM, EXECUTIVE DIRECTOR, CAREGIVERS

Ms. CHISHOLM. Good afternoon. I appreciate the opportunity to be with you today and the fact that you are showing such interest in the needs of our aging population.

I speak to you today as an advocate to bring your attention to respite care as a very unique service. We know that Americans are living longer, and we know that senior citizens are the fastest growing demographic age group. We know that most seniors have several chronic diseases which limit their independence. We know also that most of these seniors live with someone else who helps make them make it through the day.

But who helps the helper? Who helps the person who often becomes a prisoner in their own home taking care of that dependent person? Caring for a seriously dependent person may eventually rob you of social life, family contacts, and your own health.

CareGivers, my agency has provided respite care for many years. And in a demonstration research project funded through the Michigan Office of Services to the Aging, we found among other things these facts.

Spousal care givers, when they could ask for care on a regular basis, for weekends, for whole weeks at a time, instead they ask that they get respite care every week at the same time on a regular schedule. And they use that time for the things that you and I take for granted as the routine activities of life, going to the bank, shopping, getting medical appointments.

Adult children who are care givers use the time for enrichment of their life with their own family and their spouses. They go to church. They go out to dinner. They might take an overnight mini-vacation. These are still things that we all take for granted in our lives.

And in addition to that, one person carries the responsibility for caring regardless of the number of people in the family unit that we might think should be available to do that caring.

Our ongoing respite service shows us that people are desperate for respite care. Caring for a dependent person brings on deterioration that usually takes a serious toll on their family relationships. Their personal physical and mental health goes. Jobs go, outside friendships, the upkeep of their homes goes.

But the service that is usually available to them and recommended to them is one that is based on a medical health model. They are encouraged to take part in rehabilitative day care, home health aid services, personal care services or nursing home services.

From our experience we are convinced that 90 percent of the need is for a social model, which would be far less costly and which focuses on the family care giver as your primary client.

There is already one dependent in that home, and respite care can help to assure that number doesn't multiply because of the wear and tear of care giving.

The costs of a social model of respite care are dramatically less than the alternative medical care models. Nursing homes, which were alluded to here, will cost $1,800 for full-time care in a month. To have a home health aide come into your home a half a day a week from a certified home health agency would be approximately $350 a month. To attend a rehabilitative day care for a half a day a week would cost about $300 a month. But to have an in-home trained aide from a social model come in half a day a week would be $145 a month.

And Representative Kildee, you mentioned training. There are training programs that at one time were endorsed by the federal government in Title IV A and B. In the Social Security Act there could be no funds granted unless they were under—the training was done under the model curriculum supported by the National Home Caring Council. When Title XX came in in the 70's, they eliminated that. The National Association for Home Care still endorses that to be the standard that be used for federal funds so that we can assure that there is quality training.

Our society values families living a quality life at home and getting a fair return for our dollar.

Respite care is a service which helps keep families together and avoids institutionalization of our older adults, and it can be done cost effectively.

I have just focused on a few kinds of areas that I think are becoming serious issues with respite care. I would love to have a whole day with you. Instead, what I ask is that if you want to explore it further, you have my phone number. Get in touch with me. I would be very glad to work with you further on this.

I thank you very much for your time today.

[The proposed statement of M. Danice Chisholm follows:]

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April 10, 1987

Honorable Dale E. Kildee
House of Representatives
1176 Robert T. Longway Blvd.
Flint, MI 48503

My dear Mr. Kildee:

We know that Americans are living longer.

We know that "Senior Citizens" are the fastest growing demographic age group.

We know that most seniors have several chronic diseases which limit their independence.

We know, also, that most of these seniors live with someone else who helps them make it through each day.

But...who helps the helper? Who helps the person who often becomes prisoner in their home?

Caring for a seriously dependent person may eventually rob one of social life, family contacts, and your own health.

CareGivers has provided In-home Respite Care for many years. In a demonstration/research project funded through The Michigan Office of Services on Aging, we found these facts:

- Spousal caregivers request regular, weekly respite service.
- Spousal caregivers use that time for routine life business, i.e., shopping, medical appointments, banking.
- Adult children who are caregivers use the time for enrichment of life with their own spouse and children, i.e; church, dinner, mini-vacations.

Our ongoing Respite Service experience shows us that people are desparate for Respite Care. Deterioration has usually taken a serious toll on family relationships, personal physical health and mental health, jobs, outside friendships and upkeep of the home.

The service that is usually recommended to them is based on a medical model:

- rehabilitative day care
- home health aide
- personal care, and
- nursing home.

Yet, we are convinced that 90% of the need is for a social model which would be less costly and which focuses on the family caregiver as the primary client.

There is already one dependent person in the home. Respite Care can help to assure that number doesn't multiply because of the wear and tear of caregiving.

The costs of a social model Respite Care Program are dramatically less than the alternatives.

SERVICE	MONTHLY COST	
Nursing Home	$1800	(full-time)
Home Health Aide	350	(½ day/wk.)
Rehabilitative Day Care	300	(½ day/wk.)
Social Model In-Home	145	(½ day/wk.)

Our society values families, living a quality life at home, and getting a fair return for our dollar.

Respite Care is a service which helps keeps families together, avoids institutionalizing our older citizens and which can be done cost effectively.

Thank you for your concern about this important issue.

Yours truly,

M. Danice Chisholm

GAPS IN RESPITE CARE

	GAP		RECOMMENDATION
1.	Late entry in human service network leaves familes physically and emotionally bankrupt.	1.	Physicians are a key entry point for the referral source, but there must be other less traditional ways to reach out.
2.	Quality Respite Care which recognizes the customary caregiver as the client.	2.	Funders should adopt standards which require emphasis on the caregiver.
3.	Availability of a range of quality alternate care settings for Respite.	3.	Standards and licensing for day group homes, day care and out of home institutional respite care are needed.
4.	Families become so enmeshed in the caregiving, they loose their perspective on the needs of other family members.	4.	Early entry into the social service system can help with this.
5.	Insurances do not reimburse for non nursing services.	5.	The cost of nursing home placement - on Medicaid - of all of these patients would be catastrophic to the State Budget, to community life and to individual values. We must have a financial alternative for at-home non nursing care. United Fund, United Way, Area Agency on Aging, and volunteers can't do it all.
6.	The social model of service isn't being advocated.	6.	Probably 90% of clients need a social model - not health model of service. The health model will only be short term and not really impact on the overwhelming effect of caregiving.

Mr. **Kildee**. Thank you very much.

In general, with the demographics that are obviously changing, the biomedical breakthroughs prolonging life and the population controls being used, we are going to be having more older people in proportion to younger people. That is going to create an even smaller pool of people to care for the older people. So, it would seem to me that organization and training of the smaller pool becomes even more incumbent upon us.

Ms. **Chisholm**. It is very important, and it is important in all the settings, whether they are for volunteers, whether we are looking at in day care homes, whether we are looking at in adult foster care homes where someone could go for a day. Different people have different levels of dependency. Some need someone with them all the time—an Alzheimer's person, someone who has a had a stroke. They cannot be in an adult day care center always because sometimes their behavior is too disruptive or they need such specialized attention. Yet, some other people can do just fine in those kinds of settings.

So, there are a whole range of settings. And so, the training needs to be done for those folks so that they get the quality care in all those settings.

Mr. **Kildee**. Do you see often in your respite care an older female with a female daughter, both of whom have some health problems? How do we address that because the younger daughter is very often not in a position to be giving a great deal of assistance?

Ms. **Chisholm**. Then you need other services. It is only respite care if you have a person who is capable of taking care of someone. Once there is no one who is really able to be the care giver, then you are talking about other kinds of in-home supports. And you have brought out the really clear difference in your question of what the difference in respite care and other in-home services are. The others—there is someone there to normally—in respite care there is someone there normally who can take care of——

Mr. **Kildee**. Who would take care of things, would give them a chance for a change of pace in other words.

Ms. **Chisholm**. And it is not uncommon to have several adults in your care when providing personal care—other services to several adults in the home.

Mr. **Kildee**. Phyllis?

Ms. **Byrd**. In Shiawassee County we have several that I can think of right now—several situations where the mother is 92 to 97, we'll say, and the daughter is 77, you know, in that neighborhood, and not actually able to do things like a bath and so forth for the mother, but in general terms does take care of her mother. She lives there with her and so forth. And we do the personal care. We allow an hour and a half, units of service, a week for that.

And then on the homemaking units, instead of doing the housework which the 77 year old is very happy to do within her ability to do it, we get her out of the house for a while, and someone comes in to stay with her mother. We take her to—it might be to the bank or to the store. We made arrangements—because we do not have respite care in Shiawassee County, along with a lot of other things, we went to a lot of trouble to make some arrangements so that the daughter could get away overnight. She had been wanting to go to Saginaw for a long, long time—I mean, years. And so, she got to do that. And that was the biggest event in her life, quite literally, for a number of years now.

Mr. **Kildee**. I can see a combination of the two services in the same household. Let's say a 77 and a 95 year old—maybe the 77 year old can do the cooking, can do the basic housekeeping, but cannot help the older one with bathing. So, you need maybe some in-home service for that, and also some respite for the 77 year old who might want to get out to a card party too, right?

Ms. **Byrd**. Yes.

Mr. **Kildee**. So, I can see that we should make sure we maintain enough flexibility whereas not one or the other, but maybe a combination of services may be provided to that individual household.

Ms. **Byrd**. I would be really happy if you would ask us the question you asked earlier today of another group. I believe it was what did they think of the fee for service proposal.

Mr. **Kildee**. Okay.

Ms. **Byrd**. Would you like to repeat that question?

Mr. **Kildee**. I will ask that. By the way, there is an old axiom in politics. "If you're not asked the right question, give the right answer."

[Laughter.]

Mr. **Kildee**. What do you think of the fee proposal for the services?

Ms. **Byrd**. To be honest with you, I am absolutely appalled that such a thing was ever raised. First of all, I think you or someone else up here said if a thing is working, you know, don't try to fix it. And I do think that these in-home services, while they are not always adequate because sometimes we do have to turn people away or we have to reduce the hours that we can provide in order to cover all the requests we get, they do work in the rural areas. And I am speaking now of the rural areas.

And they are absolutely vital. I cannot think of any program that the Shiawassee Council on Aging has or any service that has the true value of the in-home services programs.

There are no respite care programs to speak of in Shiawassee County. There has been some talk about them, but the only discussion I know about sounded very expensive, I mean, quite a lot of money for the population we are talking about, you know, to be able to afford to pay for it. It would be a commercial enterprise and it would just be out of range of the majority of the people I am thinking of.

And I cannot imagine I guess—I am still kind of stupefied that such an idea even ever came up because, as Val Conerly pointed out earlier, the group we are talking about—they have paid the taxes and made the contributions and all those things. And I just don't see that as being appropriate at all to add fees on that.

As a matter of fact, there is a program—sort of—that I know about which hasn't ever gone very far. It was attempted that a sort of coalition of providers would do geriatric assessments, and go into a home of someone who was referred to them, and a very long assessment of 26 pages and so forth, and then basically provide them with a resource directory of where they should call to have their needs taken care of. Well, when we are dealing with the frail elderly population, this is not a very useful activity really because they are not going to make those calls for a number of reasons. The majority of them are not going to get on the telephone and call up perfect strangers. You know, it is just not going to work that way.

But for that service I recently learned there is a fee in the Flint area of $450. Now, apparently if that fee is not possible, bills are sent and they are considered uncollectible. But I am astounded by the whole concept.

Generally, the people who are referred for these types of assessments, who need assessments for services, would be the last portion of our population that could even consider a sum like that simply to be told how to be connected to some services.

Mr. KILDEE. I think the fee proposal came more out of OMB than the Department. I have always said that OMB knows the price of everything and the value of nothing.

Ms. BYRD. I was about sure that it was. And the reason I did my testimony with the dollars first is I thought that if you were collecting this for OMB, that you might want the cost benefit analysis first. I personally don't put it first, but I do know that in government there are individuals who are responsible for, you know, what are these dollars buying and what else does it relate to.

Mr. KILDEE. Does anyone else want to respond to that question? John?

Mr. PETERSON. It is just an observation of mine both personally from doing home delivered meals and also visiting a lot of sites, as you do, that people do not really fully understand the sophistication of a donation system to start with, and if you really get down to it, most people think they are paying for the services through a donation system anyway. When the person goes to get the envelope at home to give me as a home delivered meal deliver, she says, here, I need to pay for the meal. So, it would be a real mess if you go back to these people and say that now you have to pay for them because a lot of them think they have been paying for it all along.

Mr. KILDEE. Mr. Sawyer?

Do we have a copy of Mr. Crews' testimony?

Mr. CREWS. No, I have it.

Mr. SAWYER. Would it be possible for you to prepare it?

Mr. CREWS. Yes.

Mr. SAWYER. I would appreciate it very much.

One of the things that we talked about, is the notion of meeting areas of greatest need, coupled with the idea of filling in gaps in services. How do we avoid the temptation to use dollars based on areas of greatest need, that is, on the constituency for a service as opposed to those services that might be more greatly needed that could meet very specific, small gap-filling purposes?

Respite care seems to fall into that category. Certainly the notion of specific care for people with sight impairments is not something that leaps immediately to mind, and yet clearly in terms of numbers, it is a huge unmet need. How do we deal with that?

Mr. CREWS. Let me just suggest. This is my answer to a question that is not being asked. I think the public policy on parity that is before us is to begin to create an appropriate continuum of services.

Mr. SAWYER. That was the question.

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Mr. Crews. And that is no easy task. I think that begins with assessment so that we can understand the problem and begin to understand the interrelationships of the problems. And unfortunately, that is immensely complicated.

But I think given the economic argument—and I will make that argument—we cannot afford in this country to continue to provide services the way that we have to older people. We have to create models like respite care and rehabilitation services, social services, that allow us to reduce those costs. We simply cannot afford to go on in this country and force people needlessly into institutions or to wear out the family members while they try to struggle with the system with not being responsive.

Mr. Peterson. The demographics that we face just every day indicate to us that we are not dealing with a fixed situation. So much of the time these issues are put as if everything was going to be fixed.

I think there is one fixed thing and that is because there are more older people coming down the line, there are going to be more services needed. And what we really need to do is to focus on the part of the continuum that we never pay attention to, and that is the one represented in this panel here, the need for social support systems. And you want to provide services for folks in the home because by and large the level of need in the home is less complex. It is more of a social support need than it is for high-tech medical equipment. That is the part we are always focusing on because that is the very expensive part.

But one of the assumptions that we make is false, and that is this end of the continuum, that is the social support end of the continuum, is also expensive. By and large it is far less expensive per unit than the health services that the persons ends up getting whether they need it or not down the line because they have not had the necessary support services in the first place.

Nationally we are focusing on something called catastrophic illness coverage right now. And I have to even remind myself constantly that we are talking about one percent of the elderly population. That's all. In Michigan that translates to something like 9,000 people, and we have got a huge need that we are not even talking about. And that is the need for long-term care services. And you know, that's really what the problem is.

That is why we are strong advocates for in-home services because by and large that is what the people need. And that is support at home. They also want to stay at home. That is an interesting thing, too.

Ms. Chisholm. This is the process that can give the weight to those people who need it as opposed to the interests who might support opposite types of avenues for spending. So, that's how you get it, Mr. Sawyer, through this process. And you have the process of the—and the state Office of Services on Aging has their hearings, their commission hearings.

Mr. Sawyer. I understand.

Ms. Chisholm. But that really is it. And that is how it happens because each of the local area agencies—they reshape their plans regularly to these things.

Mr. KILDEE. One of the dilemmas that you face, and we face on this committee, is that we are tempted, and other people are tempted too, to take care of some of the deficiencies in Medicaid and Medicare and put them in the Older Americans Act. I recognize that temptation. I am tempted myself.

The thrust of the Older Americans Act and the service to be provided in that act is not medical; it is more social, nutritional, and preventative. We are asked, for example, at times to include Alzheimer's disease. It is very attractive for us. We know what a devastating thing that is, and yet I would prefer that the President come and say, hey, we are going to take care of that under Medicare and Medicaid.

We have this dilemma of wanting to help as many as we can, but wondering what is the more appropriate vehicle for help. And that is the decision that this committee has been wrestling with for quite some time.

With that in mind, John Crews, you talk about rehabilitation. Now, rehabilitation for a job would be handled in the Department of Labor and Department of Education, but you are talking about rehabilitation for life, aren't you? For quality of life. That may be something properly handled by the Older Americans Act. You are not talking about getting these people back to where they can go and run a lathe, but so they can move around their home, and do some cooking in their kitchen without burning themselves because of a vision impairment.

Mr. CREWS. Public policy in this country in regard to rehabilitation is being controlled by a vocational rehabilitation model.

Mr. KILDEE. That is right. It does control it.

Mr. CREWS. Absolutely. When you look at the disabled population, that simply does not make sense. Vocational rehabilitation is only addressing a very small proportion of the disabled population. We have talked about social kinds of issues and certainly life is doing the kinds of daily living activities. That defines our lives. Work is a piece of that, but if one is so severely disabled one cannot enter into the work environment, then certainly there are points where it does not make sense for somebody 79 to be looking at vocational—to look at a model of vocational rehabilitation.

I think one thing we might look at though is that obviously the demographic inherent in this country is forcing public policy changes. No doubt about it.

An interesting one to look at is the medical model. Even though we kick it around a lot, the medical model is shifting this country. It is moving from acute care to prevention. And I wager that everybody in this room has changed dietary habits in the last three or four years, and we are not eating at McDonald's as often as we used to, and trying to diminish the amount of fat that we have in our diet. The medical model is recognizing that it makes sense both in terms of dollars and cents and in terms of quality of life to look at prevention and not acute care. That is a policy shift. It was very subtle, but it was controlling all of our lives. I think that is what we are seeing today.

Someone remarked some time ago that it is not stones but feathers that makes the difference in the ability of a person to live independently. And we are talking about the feathers today.

Mr. KILDEE. In the health aspect of the older American, the Older Americans Act is more involved in fire prevention than putting out the fire. All analogies are limp, but you know that one maybe fell down.

For example, Meals on Wheels certainly has a health aspect to it because it provides a nutritious meal. Many of these things have a mental and physical health aspect to them.

I think you are right. Rehabilitation has been geared in this country pretty well toward a job orientation. Tere may be some person losing their eyesight who wants to be able to move around that house in which they still want to live, who wants to know how to use that stove without burning themselves. I think that can be done. You are familiar with that?

Mr. CREWS. We have a pretty good success rate in doing it.

Mr. KILDEE. Right. They have to be really motivated sometimes, too, because they are afraid. That type of rehabilitation for the elderly who have lost their sight is a very, very important thing if we are going to respect the human dignity of that person. They are often bewildered, really isolated, because the things that they were able to do at one time in their own house, now very often has become frightening or impossible because of the loss of sight.

Mr. CREWS. I will tell you my favorite anecdote in 10 seconds.

Mr. KILDEE. Okay.

Mr. CREWS. We had a client some time ago in our services who was 87 years old, and she was homebound. She did not travel outside of her house. And we sent our orientational ability instructor to her home. And the first question that she asked him was would you take me to my basement because I haven't been down there in five years.

Our miracle in that story—and we do not perform miracles all the time by any means, but our miracle is that we taught that woman to use the bus system to travel across town. In terms of her quality of life, I think she would give us glowing reports.

That is not typical I don't think, and we should not make that a typical model by any means. But that kind of isolation does occur. Rehabilitation then allows a person then to have that degree of independence and sustain that level of quality of life. And we think it is very important in terms of a continuum of services that are available to older people.

Mr. KILDEE. That really enhanced human dignity, didn't it?

Mr. CREWS. Yes.

Mr. KILDEE. I want to thank this panel very much. Very often what we need here in the Congress is not only that our intellects be enlightened, but our will be strengthened too. I think you have done both here today. Thank you very much.

Our next panel consists of Nondi Orazi, The Information Center, Wyandotte, Michigan; Joe Benavidez, whom I have known for more years than we care to tell, Michigan Office on the Aging; Al Kleyps, Executive Director of the Trio Council on Aging; and Mary James, Staff of the Michigan Office on the Aging.

Okay, Nondi. I think you are first.

STATEMENT OF NONDI ORAZI, THE INFORMATION CENTER, WYANDOTTE, MI

Ms. **Orazi**. Hi. What I provided you is a little case study.

I am from The Information Center in southern Wayne County, so I had a distance to travel, too, Mr. Sawyer. I am happy to be here.

Area agency 1B contracts with us to provide extensive comprehensive information assistance, advocacy and that type of thing for older adults. And we get about 10,000 calls—10,000, 11,000 calls a year. So, we feel like we have a pretty good idea of what kinds of needs are out there. And we try to fill in gaps, find private sector resources to tap when we cannot get a person served through the normal channels through all these great in-home services that are provided, and so many more are needed.

I just received a thank you letter from a client just a couple days ago. So, that is included in my case study.

They told me I had two to three minutes to talk, so I am going to talk real fast. You're flexible?

Mr. **Kildee**. We just abandoned that rule a couple hours ago.

Ms. **Orazi**. No, no. I talk fast for a southerner.

This case study is pretty typical. It does not tell you about the cases that we deal with that involve the Department of Social Services, adult protective services, and really hard to comprehend cases that some of our elderly people get into. And it does not tell you too much about the case of the person who just needs the Social Securities phone number or the home delivered meals phone number. So, this is kind of a middle of the road case.

This is Laura. She is 69 and her husband was diagnosed with cancer a couple years ago. He is about 73. And they moved into the area, and they didn't know too much about southern and western Wayne County. And she found us and called and just wanted some information about how to draw up a will and some information about some housekeeping. And we provided her the Title III funded agencies that do that.

She then called back a few months later and said her husband was diagnosed as having cancer and she was going to have knee surgery. And she needed help convalescing. Again, our information and referral specialists provided her with the home health care agencies and the Title III funded home delivered meal program to provide her some assistance while she was recovering.

She then again called and was very overwhelmed with her husband's illness. And her husband as having a four to six months' time to live. We referred her to the hospice of southeast Michigan. I am just trying to give you an overview of some of the services out there, and some of the ways we connect people up with them. We called to check in on her also.

Then she called back a few months later. She was receiving—hospice was visiting her home and she wanted additional housekeeping. And the I&R specialist remembered that they had offered her some housekeeping before and evidently she was a bit confused. So, the staff person got on the phone on her behalf and called to make sure that was in place and if there were any problems to work out there.

She also mentioned that the couple's income was about $800 a month, and was just over the Department of Social Services guidelines. And she could not get adequate—her income was not adequate to get the help she needed although she didn't qualify for DSS assistance.

Let's see. The client called again and she initially talked about her need for housework, but proceeded to share other issues. Her husband was drinking excessively and was very ill and often verbally abusive. And the client was then ready to seek some counseling. So, again the staff person got on the phone with Catholic Social Services to try to find some in-home counseling for her. The woman was fairly house-bound with her husband who was deteriorating at a rapid rate, and she, of course, had just had knee surgery recently.

We then around the holiday season tagged her case as someone that was pretty critical, and had a food basket delivered to her that was donated by a local businessman. A few days later she called to thank us for that support.

Then the client, who was recently widowed in March, called back. Her income had been reduced. She needed emergency prescriptions for her high blood pressure, glaucoma and diabetes. She had no money left from her check. Fourteen calls later we came up with three sources to provide her with $184 worth of emergency prescriptions. And we talked with her about some Medicare HMOs and told her the benefits of some high option plans assisting with prescriptions.

The client does not drive and she needed transportation to the doctor, and the senior transportation was not available on the right days, et cetera, and we were able to locate her a volunteer driver to take her to the doctor.

Later we got some information from a hospital that was offering free health transportation, and we called her a couple weeks later to let her know that that was a new program that had just started.

She was talking with us, and some other things came up. As recently as April, we referred her to telephone reassurance and Focus Hope food program to deal with some of her isolation and her emergency food needs, as well as her—she was still getting over her grieving of her husband. And she needed a friendly call once a day. We felt like that would be a good recommendation for her.

Now, she sent us a thank you note. And she is probably much more articulate than I am in terms of what she needed and how she felt gaining access to all these services worked for her. And the thank you note is on a little green piece of paper. And basically, you can read it, but it just so says so much about the need for access. And I think that is the beauty of the Older Americans Act. It takes access and makes it a priority. And I think we have talked quite a bit about access and how important it is for our older adults.

I am supposed to be talking about access, but I can only say in listening to all of us talk about what we are here today, that I myself am a young adult, and I want to live in my home as long as possible. And I hope that we will continue to expand these kinds of programs so that I can do that and have the same consciousness about the folks that are older adults today and really focus on helping them remain independent and live in their home as long as possible.

And I think a real comprehensive I&R program, a lot of in-home services, transportation and an increased awareness and some housing—housing comes up daily for our office. People are just really seeking a lot of—better alternatives because the subsidized and the cooperative housing that they thought would be available is no longer.

So, with that, I'll pass to Mary James or whoever is next.

[The prepared statement of Nondi E. Orazi follows:]

THE
INFORMATION CENTER, INC.

3221 Biddle Avenue Wyandotte, Michigan 48192 (313) 282-7171

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Executive Director

The Information Center, Inc. provides comprehensive information and referral, outreach, assistance and advocacy to the older residents of Southern and Western Wayne county, Michigan. This service is funded, in part by the Area Agency on Aging 1-C, The Senior Alliance as a priority service for older adults to gain access to service.

Clearly the importance of providing access to services for older adults is illustrated in the Case Study below:

10-15-85 Laura M age 69 contacts The Information Center (TIC) needing medical attention. The Information and Referral (I&R) Specialist notices the client is upset and talks with her to determine all her needs. She and her husband, age 73, have recently moved to Wayne, Michigan from Detroit and feel they need overall medical attention. They also want to make out a will and their income is limited although above the Michigan Dept. of Social Services guidelines. Mrs. M feels Mr. M's health is bad in general and needs some help around the house as well.

ACTION: Referrals given to client: Title III funded Senior Citizen Legal Aid Project; Title III funded Health Screening program; and Title III funded Housekeeping program.

1-3-86 Laura calls again as Mr. M has been diagnosed as having cancer. Mrs.M will be having knee surgery and will need help convalescing.

ACTION: Referrals given to Home Health Care Agencies and Title III funded Home Delivered Meal Program.

2-7-86 Mrs. M calls again very overwhelmed with husband's illness and doctor has estimated 4-6 months life expectation time for her husband.

ACTION: Referral to Hospice of South East Michigan.

Continued

"WHERE PEOPLE WITH QUESTIONS CALL PEOPLE WITH ANSWERS"

3-9-86 I&R Specialist call to check on Mr. and Mrs. M.

ACTION: Provided support but no new referrals given.

5-28-86 Laura calls. She now has home hospice team and wants additional help with housekeeping. Client seems confused about previous contacts.

ACTION: I&R Specialist gets release from Mrs. M. She calls Title III Home Delivered Meal Program on her behalf and service is scheduled to start within a week. Also, a call to Title III Housekeeping provider revealed their home is being cleaned once a week for 3 and a half week period. The couples income of $803/month while over guidelines for the Dept. of Social Services is not adequate to hire additional help. The Hospice volunteer does provide respite. I&R Specialist empathizes and offers suggestions about counseling to help Laura cope. Client not willing to seek counseling at this time.

8-18-86 Client calls and initially talks about help needed with housework but proceeds to share other issues. Her husband is drinking excessively, is very ill and often verbally abusive. Client is now ready to seek counseling.

ACTION: I&R Specialist arranges for Catholic Social Services to provide in-home counseling. Referrals to the Cancer society for information and support group are also suggested and client agrees to investigate.

12-15-86 ACTION: Provided Holiday food basket as medical expenses and limited income have increased. Food basket was donated by local businessman.

12-16-86 Laura calls to thank TIC for support and basket.

3-10-87 Client is now widowed and her income has been reduced. She needs emergency prescriptions for high blood pressure, Glaucoma, Diabetes. Laura has no money left from her check.

ACTION: I&R Specialist advocates on Laura's behalf and obtains funding from three sources to get her $184.00 in emergency medication. This involved fourteen phone contacts. Also, referred client to Medicare HMO's and told of the benefits of high option plans assisting with prescriptions. Client does not drive and transportation was arranged by I&R Specialist for volunteer to drive Laura to Doctor's office. Referral for senior transportation is not available on right days, etc.

Continued

3-31-87 I&R Specialist called client to tell her about new transportation service, "Health Connector" that could take her to Annapolis Hospital where she has Doctor appointments.

4-1-87 Laura called to thank TIC and I&R Specialist, Joan Johnson for all assistance. Also discussed status of her situation.

ACTION: Referrals made to telephone reassurance and Focus Hope food program. Hospice is still working with her as Linda is still grieving and her health and finances are a problem for her. She is, however, coping and now has confidence that "she can make it".

4-3-87 The Information Center received the enclosed thank you letter and permission from Laura to share it with you.

Case Study submitted by
Nondi E. Orazi
Executive Director
The Information Center

4-11-87

March 30, 1987

Ms. Mondi Orsi, Director,
Information Center, Inc.
3221 Biddle Avenue
Wyandotte, Michigan

Dear Ms. Orsi;

I read something somewhere like this "when a 'feller' needs a friend". I found this phrase very true when I became a Senior Citizen.

My troubles began when my husband's illness became terminal. It lasted two long years. I didn't know about Information Center until last year. I was trying to find a bell because my husband could hardly speak above a whisper, and I knew a bell would help. Somehow, someone referred me to Joan Johnson. We received the bell first, then Joan Johnson next.

I don't know now to describe the efficiency of Ms. Johnson. If she did not have the answers she would find someone who could give the need or the answers. Then she had a way of following up, making sure that everything went along well. I found myself calling her for advice, too. In fact, her staff Pat Nielsen and Ann worked with me. They too, were SUPER. I do not understand why I did not know about the Information Center sooner. I do hope other Seniors can get to know about these services.

My husband passed away in January. Joan Johnson did so ~~many~~ much to help. As usual when one is widowed, her financial support is lost, bills come in, but through Joan's help and advice things did not go hard for me. I had food, medication and a peace of mind as much as one could expect from a widow.

I certainly thank you for Joan Johnsonwhose heart is in her work and she is sympathetic for those she help. All my troubles are not settled yet, but with God leading and Joan encouraging, we can make it. Thank you so much!

Very truly yours,

Laura

Mr. KILDEE. I think Al will be next.

STATEMENT OF AL KLEYPS, EXECUTIVE DIRECTOR, TRIO COUNCIL ON AGING

Mr. KLEYPS. Thank you. Mr. Kildee and Mr. Sawyer, I appreciate the opportunity to speak to you on behalf of the Older Americans Act today. I was also told to limit it to two or three minutes, but if you don't mind, if I digress a little at the end of my prepared statement on a couple of issues that I think are very relevant in relationship to the Older Americans Act.

First of all, I am Albert Kleyps, director of Trio Council on Aging. As a northern Michigan rural service provider, I would like to provide testimony in support of the programs which are funded through the Older Americans Act provisions. In particular, I will address the topics of demographics and service delivery as it relates to the rural service provider.

Northern Michigan is a beautiful area in which to live, work, play and also retire. The elderly population in northern Michigan is currently the fastest growing segment of our society. In the Trio Council on Aging counties of Roscommon, Ogemaw and Iosco, senior populations have escalated dramatically in recent years. According to census data the 60 plus population in Roscommon County grew by 79.71 percent from 1970 to 1980. Ogemaw County experienced a 40.98 percent jump during the same period of time. Iosco County, which has the largest senior population in all of Region IX, grew by 18.7 percent. While senior population increase is not a problem in itself, the need to have a consolidated care network in respect to access services is vital.

Northern rural senior centers have become a focal point in the community by providing comprehensive services to the senior citizen. These services not only include congregate meals, education, recreation and socialization, but also services for the homebound elderly as well, many of whom are living in an isolated setting.

Rural outreach through the senior center is an important link for many older Americans who depend on staff and volunteers to keep them as independent as possible in their homes. By identifying the needs of isolated persons, many problems can be solved through senior centers. Oftentimes this is their only contact with others. In many instances services provided through the rural council or commission on aging are the only ones available to senior citizens.

Health care facilities, recreational opportunities, enrichment programs and education are limited. Even when such systems are available, distance may be an inhibiting factor for many seniors.

Outreach provides a linking mechanism to the isolated homebound senior. Access services such as home delivered meals, chore, homemaking and personal care afford many persons the opportunity to maintain an independent living standard. Many clients need only a few hours per week to avoid an institutionalized setting. It is a very cost efficient method of service provision.

In summation, the availability of senior centers in combination with appropriate outreach and access services provides a variety of critical services. Without these services the elderly population would be lacking even basic services necessary to maintain an acceptable lifestyle.

Thank you. And if I could make two comments please.

One would be on the possibility of raising the age limit from 60 to 65 or 70 or whatever is being talked about. I strongly oppose this talk. It would not only inhibit our ability to provide to a needy population, but also I do not know if you are aware of the fact that many of our home delivered meal drivers and volunteers are the "younger older" population. Without our 61, 62 year old people working out of our centers, we are going to be in bad shape. And we simply do not have the staff nor the funding to supplement if we lose those 60, 61, 62 year old volunteers. We cannot do it.

The second point that I would like to go on record as opposing would be any type of sliding fee scale which is mandatory or a means testing system for the Older Americans Act.

And if there are any questions on these two particular points or my prepared statement, I will be happy to answer them.

[The prepared statement of Albert Kleyps follows:]

PREPARED STATEMENT OF ALBERT KLEYPS, DIRECTOR, TRIO COUNCIL ON AGING

Rural Services for the Elderly

Good afternoon ladies and gentlemen:

I'm Albert Kleyps, Director of Trio Council on Aging. As a northern rural service provider I would like to provide testimony in support of the programs which are funded through the provisions of the Older Americans Act. In particular, I will address the topics of demographics and service delivery as it relates to the rural service provider.

Northern Michigan is a beautiful area in which to live, work, play, and also retire. The elderly population in northern Michigan is currently the fastest growing segment of our society. In the Trio Council on Aging counties of Roscommon, Ogemaw, and Iosco, senior populations have escalated dramatically in recent years. According to census data the 60+ population in Roscommon County grew by 79.71% from 1970 to 1980. Ogemaw County experienced a 40.98% jump during the same period of time. Iosco County, which has the largest senior population in all of Region IX, grew by 18.7%. While senior population increase is not a problem in itself, the need to have a consolidated care network in respect to access services is vital. Northern rural senior centers have become a focal point in the community by providing comprehensive services to the senior citizen. These services not only include congregate meals, education, recreation, and socialization; but also service the homebound elderly as well, many of whom are living in an isolated setting. Rural outreach through the senior center is an important link for many older Americans who depend on staff and volunteers to keep them as independent as possible in their homes.

By identifying the needs of isolated older persons, many problems can be solved through the senior centers. Often times this may be their only contact with others

In many instances services provided through the rural council or commission on aging are the only ones available to the senior citizen. Health care facilities, recreational opportunities, enrichment programs and education are limited. Even when such systems are available, distance may be an inhibiting factor for many seniors.

Outreach provides a linking mechanism to the isolated homebound senior. Access services such as home delivered meals, chore, homemaking, and personal care afford many persons the opportunity to maintain an appropriate living standard. Many clients need only a few hours per week to avoid an institutionalized setting. It is a very cost-effective method of service provision.

In summation, the availability of senior centers in combination with appropriate outreach and access services provides a variety of critical services. Without these services, the elderly population would be lacking even basic services necessary to maintain an acceptable lifestlye.

Thank you.

Mr. **Kildee**. Thank you very much.

Mr. Benavidez?

STATEMENT OF JOE BENAVIDEZ, MICHIGAN OFFICE OF SERVICES TO THE AGING

Mr. **Benavidez**. Dale, welcome back. Mr. Sawyer.

I am Joe Benavidez, Hispanic Affairs and Transportation Analyst for the Michigan Office of Services to the Aging.

Society is very quick to forget who has made our country strong, powerful, rich and beautiful. Our elderly have served in past wars, built our railroads, our highways and our factories. Yet, our elderly are the first to face mounting problems regarding their health and their income.

Among the biggest problems has been the lack of accessibility to services. And I repeat that we have been talking about access, humane and all these other things, but accessibility is not there for most of the seniors, especially in the inability to get to the doctor and for outpatient services at hospitals.

A few years ago a group came to the state office and the Commission on Services to the Aging with the same problem. Transportation services for the elderly and the handicapped with adequate equipment and trained personnel were lacking in southwest Detroit. Elderly and handicapped were unable to get to doctors and to hospital services. In 1985, with the help of State Representative Ray Murphy, staff from the state office, and the state Department of Transportation and a variety of local public and private agencies, the Detroit Assisted Transportation Coalition started implementing Operation Let's Go initially as a demonstration project. Let's Go offers door-to-door transportation service with properly trained individuals to low income minority and handicapped persons.

Thousands of elderly and handicapped are being serviced through the Let's Go program. They are free from the fear of crime, which has plagued them previously. Elderly and handicapped in Detroit have formed a mutual bond with each other. Trips together are enjoyable. They seem to have gotten a new lease on life. As a group, they have found a new sense of enthusiasm which you cannot say very often about seniors. The success of Let's Go has exceeded everyone's expectations.

The Michigan legislature funded Let's Go. The state aging network provides the impetus for coordination in Detroit. This is the important role we perform.

There is simply not enough money in the Older Americans Act appropriations to meet Michigan's elderly transportation needs. As it is, we spend nearly $850,000 of our Title IIIB allocation to purchase transportation services.

As we view our present and future transportation needs for the elderly and handicapped in Michigan, we feel the federal government should earmark Department of Transportation funds for programs such as Let's Go. We recognize that the federal transportation funds are not part of the Older Americans Act. However, now that you have learned about Michigan's Let's Go program, you will appreciate our dual plea for both more transportation dollars and even a stronger mandate in the Older Americans Act to insure that all elderly and handicapped have total accessibility services.

[The prepared statement of Joe Benavidez follows:]

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STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
OFFICE OF SERVICES TO THE AGING
OLIVIA P. MAYNARD, Director

COMMISSION
JOSEPH A. RIGHTLEY
CHAIRPERSON

TESTIMONY
BEFORE THE
HUMAN RESOURCES SUBCOMMITTEE
OF THE
U. S. HOUSE OF REPRESENTATIVES
TRANSPORTATION

April 10, 1987

I am Joe Benavidez, Hispanic Affairs and Transportation Analyst for the Michigan Office of Services to the Aging. Society is very quick to forget who has made our country strong, powerful, rich and beautiful. Our elderly have served in past wars, built our railroads, highways, and factories. Yet our elderly are facing mounting problems regarding their health and their income. Among the biggest problems has been the lack of accessibility to services, especially the inability to get to the doctor or outpatient hospital services.

A few years ago, a group came to the State Office and Commission on Services to the Aging with just such a problem. Transportation services for the elderly and the handicapped with adequate equipment and trained personnel were lacking in southwestern Detroit. Elderly and handicappers were unable to get to the doctor and hospital services. In 1985, with the help of State Representative Ray Murphy, staff from the State Office, the State Department of Transportation, and a variety of local public and private agencies, the Detroit Assisted Transportation Coalition started implementing OPERATION LET'S GO (initially as a demonstration project). LET'S GO offered door to door transportation service with properly trained individuals to low income, minority, and handicapped persons.

Today, thousands of elderly and handicappers are being served through the LET'S GO program. They are free from the fear of crime which had plagued them previously. Elderly and handicappers in Detroit have formed a mutual bond with each other, trips together are most enjoyable. They seem to have gotten a new lease on life. As a group, they have found a new sense of enthusiasm. The success of LET'S GO has exceeded everyone's expectations.

The Michigan Legislature funded LET'S GO. The State Aging Network provided the impetus for coordination in Detroit. This is the important role we perform. There is simply not enough money in the Older Americans Act appropriations to meet Michigan's elderly transportation needs. As it is, we spend nearly $850,000 of our Title IIIB allocation to purchase transportation services.

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We recognize that Federal transportation funds are not part of the Older Americans Act. However, now that you have learned about Michigan's LET'S GO program, you will appreciate our dual plea for both more transportation dollars and an even stronger mandate in the Older Americans Act to insure that the elderly and the handicappers have total accessibility to services.

JB/JP/rd

4.11.87

Mr. **Kildee**. Thank you, Joe. Thank you very much.

Mary James?

STATEMENT OF MARY JAMES, STAFF, MICHIGAN OFFICE OF SERVICES TO THE AGING

Ms. **James**. Thank you so much. I am mercifully the last speaker that you have to listen to today, and I will try to be——

Mr. **Kildee**. You get the door prize. [Laughter.]

Ms. **James**. What is second prize?

I am here on behalf of the Michigan Office of Services to the Aging to share some information on that very important access service, case management, or as we call it in Michigan, care management.

The Office sees that the coordination of home and community based services is going to become an increasingly important priority for our network in the years to come. And we have put forward that we feel that this should be brought to the level of being a state plan requirement and a mandated area agency activity. And we would also like to propose that care management is a very appropriate vehicle to attain that goal.

Now, very much earlier today, Chairman Kildee, you asked is it fiscally feasible, is it humanely feasible, to provide in-home services. And I believe that we have some data on our care management projects that would answer at least in part some of those very complex questions.

First, to give you just a very brief overview, we have nine care management projects in Michigan with special appropriations from our legislature. And they work to target the most vulnerable, the most frail of people who are living at home. Everyone who goes into a care management project has been pre-screened to look not only at their physical frailties, but at the absence or the failing social supports and their mental wellness, their mental status. So, we are dealing with the most frail of people.

In fact, all these people would meet the Medicaid certification for basic or intermediate in our state—intermediate care facilities. So, they would be nursing home eligible. But these are people who have reached out to the care management projects to try to stay at home.

When we first started doing care management projects, there was a great focus—and there continues to be a great focus on insuring that we are doing something that is valuable. So, we had to undertake some research to look at the impact of this project.

And what we did was we did a classic experiment, and we have done this in seven of the nine projects. And that meant that we randomly assigned people who passed the pre-screen into either a control group who received whatever services they would normally receive in the community, and then a care management group who got that added service of care management. And we followed these people for varying amounts of time, continue to follow some of them, because not all of our research is over, to see what the effects have been. And we have to share with you some data from our first project from Western Michigan University, which has found some vast reductions in many acute care services that the care managed group just avoided using. And we found 25 percent fewer inpatient hospital admissions. We found 24 percent fewer doctor office uses except for regular checkups. We found 13 percent fewer emergency room visits, and 18 percent fewer placements in dependent care settings, whether those would be nursing homes which were 12 percent less, or adult foster care facilities, which are 6 percent less.

Now, that was after 15 months after the entry into the program. And most of these data, although they have changed somewhat over a two-year period, have remained. So, to answer your question, is this fiscally feasible, this data at least—and it is not from all of our projects; it is only from one—would say, well, perhaps, because if you are avoiding utilization of high-tech costly services, perhaps you can save some money.

And I think that we found something that perhaps is different than a focus in other states which is always looked at as can you save money by avoiding nursing home institutionalization. We have looked at—we discovered really that perhaps we could avoid acute care hospitalizations. We do not know that this impact will show in all of our projects, but if it only shows part of the time in Flint, I am sure the average hospital daily rate is well over $500. And that is a lot of money saved from spending if we are avoiding putting people in the hospital.

As regards the second and much more complex issue of, is this humanely possible, we would say overwhelmingly certainly it is. We believe that care management serves a variety of functions. Not only can it help people avoid costs that if they don't have to pay, then they can spend elsewhere. But really the key to care management is that we are able to tailor very individually what a person needs. And that certainly enhances their autonomy where we are being able to carry out their preferences as well as their needs. Many older people's preferences in an institutional setting will just be overlooked because that is the way it is. But in-home we can respond to their preferences.

Very critical is that in our recent statewide needs assessment, our survey of needs, we found that 80 percent of our older people wanted to stay at home. The only place they wanted to go less than to a nursing home was to live with their kids. And we helped them carry that out, and that is a real important function. We help them stay at home.

And lastly, I think that this is something that we are again just discovering about our projects is that the care managers, because they are in the home, because they have an ongoing relationship with people who might be very isolated—many of our clients do live alone and may have no other friends or family. We are serving a quality assurance function.

And the issue of quality assurance is really emerging in our network for in-home services, and how are we going to assure quality. And we think that having a care manager there, somebody who keeps in contact with that client, helps provide that. We know whether the services were delivered at all. We ask our clients whether they were delivered in a manner that the client appreciated and found compatible, and in some cases we have changed providers, and we help them readjust according to their needs and their preferences.

So, we have a maybe for fiscally feasible and a certainly for humanely feasible.

Thank you.

[The prepared statement of Mary James follows:]

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STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

OFFICE OF SERVICES TO THE AGING

OLIVIA P. MAYNARD, Director

COMMISSION
JOSEPH A. BENTLEY
CHAIRPERSON

TESTIMONY
BEFORE THE
HUMAN RESOURCES SUBCOMMITTEE
OF THE
U.S. HOUSE OF REPRESENTATIVES

SUBMITTED BY
THE MICHIGAN OFFICE OF SERVICES TO THE AGING

CARE MANAGEMENT

APRIL 11, 1987

Michigan care management is a program designed to find, mobilize and manage a variety of home care and other services needed by frail elderly persons aged 60 and older at "high risk" of entering a nursing home. Following a prescreening which determines eligibility for the program, a comprehensive assessment is conducted by a team comprised of a nurse and social worker. The assessment identifies the person's needs as well as existing supports and resources. Care managers next develop a plan of care. This is done in conjunction with the person and members of his or her support network. In planning, care managers utilize all available informal resources prior to arranging formal services for the person to remain in his or her home. Services are brokered which means that the care managers arrange for the frequency and duration of the in-home services. Costs are thereby monitored and controlled. Only services necessary to enable the person to remain at home are engaged. Finally, care managers reassess the person's needs at least every 3 months following implementation of initial services.

Care management is a system of coordination which is intended to avoid costly, premature or inappropriate institutionalization of the high risk, frail elderly. It defines appropriate types of care needed to assist the elderly to maintain independence utilizing formal and informal supports.

Currently, Michigan funds nine care management projects at various sites throughout the State with special appropriations by the State Legislature. The projects utilize a variety of staffing models and are either contracted through the Area Agencies on Aging or are operated by AAA staff. Research has been and is being conducted to determine the efficacy of utilizing the care management approach to respond to the multiple and complex needs of the frail population of elderly.

Thus far, Western Michigan University has completed its program evaluation of the care management project directed by Region 4 Area Agency on Aging. The project covers the Area Agency's planning and service area in southwestern Michigan. The research study demonstrates clearly that Care Management has a long term positive impact on selected variables pertaining to health, security and daily care, financial concerns, routine home maintenance, and the use of basic equipment. Statistically significant beneficial differences for those high risk elderly receiving care management, in comparison with those receiving services normally provided in the community, were evident in seven of the twenty variables measured between initial interviews and the second interviews which took place fifteen months later.

Care management clients utilised all health services with less frequency during the project year than did the control group. For care management clients, this meant approximately:

* 25% fewer in-patient hospital admissions
* 24% fewer out-patient doctor visits (for other than regular checkups)
* 13% fewer emergency room visits
* 12% fewer nursing home placements
* 6% fewer foster care placements

Researchers conducted a third round of interviews twenty-one to twenty-five months after the first interviews. The positive trends noted in the second round continued into the third round. In this case comparisons are made between the first and third interviews. This meant for the care management clients approximately:

* 20% fewer in-patient hospital admissions
* 9% fewer out-patient doctor visits (for other than regular checkups)
* 44% fewer emergency room visits
* 9% fewer nursing home placements
* 5% fewer foster care placements

None of the findings at the third and final round of interviews is statistically significant due to a high attrition rate (74%) among the original sample group. Of the 95 high risk elderly in the sample pool, only 25 (26%) remained in the study group 25 months later. Too few cases remained in the study to conduct tests of significance for reliable inferential analysis.

In analysis of this attrition, no significant differences were found between those who died and the original entire sample for the demographic categories of race, marital status, age and living arrangements. However, there was a significant difference between the deaths of men and women. Whereas, men comprised less than 1/3 of the original sample (31.6%), they accounted for over 1/2 (55.1%) of the deaths. There were no significant differences in deaths between the control group and the treatment group. 31.8% died in the control group and 29.8% died in the treatment group.

The positive correlation between reduced utilization levels and a reduction in health care costs has been recognized for a long time. We are confident that the continuing reduction in utilization established by this research will show substantial savings in public health care dollars. Currently, the University of Michigan and Michigan State University researchers are comparing public health care costs between experimental treatment and control groups.

We see care management as having numerous benefits, both to older people and to the Aging network. Because of its specific focus on the frail and vulnerable, we are able as a network to move forward on the Older Americans Act mandate to target the elderly in greatest need. We are impressed with the capacity for care management to tailor services and social supports to the individual preferences and needs of particular clients, thus enhancing older persons' autonomy and self-worth. Care management has demonstrated its capacity to reduce the elderly's use of oftentimes expensive health care services. Lastly, we believe that the role of care management as monitor of services provides a valuable quality assurance function, a function particularly hard to implement in non-institutional settings. These benefits render care management a key access service.

To quote the Administration on Aging Commissioner, Carol Fraser Fisk, "The Older Americans Act draft bill would require State plans to provide assurances that Area Agencies will facilitate the coordination of community-based services to older individuals residing at home, in hospitals, or long-term care facilities, who are at risk of institutionalization but who could remain in or be returned to the community if community-based services were available." We support this initiative. We also agree with Commissioner Fisk that coordination of home and community-based services for the vulnerable elderly has become an increasingly important service priority that should be a State plan requirement and a mandated area agency activity.

In the immediate future, Michigan is looking to improve the care management system by improving assessment, care planning and monitoring processes and by establishing care management standards and a statewide computerized data base system. Additionally, we anticipate with eagerness that the Comprehensive Omnibus Budget Reconciliation Act of 1986 becomes a reality of federal reimbursement for our system. We also look for expansion into the AAA regions that are currently not funded for care management services.

Mr. KILDEE. Thank you very much. I appreciate that.

The subcommittee has been requested to consider an amendment to the Older Americans Act that would permit area agencies to provide case management, care management, as an access service without seeking a state waiver, as required under the present authorization. Would you support such an amendment?

Ms. JAMES. Well, we support the notion that care management services ought to be carried out through area agencies. Whether they provide the service themselves or whether they choose to subcontract, we see that it is important that they are given that capacity to do that service coordination and to decide for their area.

Mr. KILDEE. Right now they can do that as an access service, but it requires a waiver from the state. Does a waiver from the state create any problems for the area agencies?

Ms. JAMES. Well, we do not see it as—we have granted waivers, and these are demonstration projects. And we do not feel that it is a direct service. It is a coordination service. So as far as granting them—not having to do a waiver, I would say yes.

Mr. KILDEE. There is no problem though with the waiver in Michigan. Is that what you are saying?

Ms. JAMES. No. We have granted everyone a waiver because they have had to compete for the funds and because we are very solidly behind what they are trying to do.

Mr. KILDEE. Joe, let me ask you this. You are involved in transportation, and it is hard to evaluate it, but if you were to measure the adequacy of transportation services for our senior citizens, what they need on a scale from 1 to 10, how would they rate? I know Joe answers these kinds of questions all the time. So, roughly where would you place it, Joe?

Mr. BENAVIDEZ. About a minus 1.

Mr. KILDEE. Pretty bad. You would consider it almost nonexistent?

Mr. BENAVIDEZ. In some cases, it is like nonexistent. And when we talk about access, you talk about people that watch TV and read the newspaper and stay up with the Federal Register and what it is that is going on at the state capital. And a lot of people, you know, when they become blind and they have hearing impediments and they are having difficulty with other problems, they never have access to a lot of information on services. And consequently, not too many of them receive like what I talked about here in Detroit.

One agency that was CHAS, which was providing preventative medical services, used to service 2,500 senior elderly prior to 1980, and in 1980 all of the federal cuts start coming down. And the city was providing that agency money for them to hire a driver and have transportation to bring seniors to the CHAS. And if they had any major difficulty, they have a contract with a hospital which they were getting all these services at 25 percent of the cost if they didn't have any insurance. And when we look at that, only one-fifth of that group was being served. And that is just one example of one area.

The other thing is we have to talk about attitudes and the special handling and dealing with seniors. The average taxi driver does not have that training. And the people that are working in this Let's Go program receive a week's training from the Department of Transportation as to how they deal with it. And you have a group of seniors that are traveling with other seniors and handicappers. And that is a real strong bond with them because they are not afraid of anything.

And we always look at the cost factors as to how much does this cost. But I didn't see anybody raise any stink when that last missile blew up, you know, and cost close to $200 million. And the attitude of everybody it was like somebody just spilled a cup of coffee. If we are going to have complete access and accessibility to everything, we have to let everybody in Congress look at elderly needs and handicapper needs and they see that Pentagon budget.

Mr. **Kildee**. I am going to use that line back in Washington, Joe. A cup of coffee. A good one.

Tom?

Mr. **Sawyer**. It sounds to me that you are talking about services that show demonstrable benefit in terms of absolute condition that clients are in. And yet I suspect that these kinds of services that in the past when not formalized, nevertheless are going on and have been conducted informally, when either a client demanded it of a service deliverer or where a deliverer felt strongly about the need to do it that they reached out and carried it out. It probably goes on every day of the week in areas which because of economies of scale, simply have to do that or they sit there without rendering services that the givers consider adequate in the first place.

How are these accounted for when you do not have a special program, when you do not have a demonstration project? Do these fall under administrative costs?

Ms. **James**. The area agencies are very outspoken about their belief that they need separate dollars to do this for very vulnerable, frail people. I think that in some cases you have I&R programs or outreach programs that an individual person can do that for another individual older person. But in terms of capacity, the capacity just is not there. There are many, many more old, old people. There are many, many more frail and vulnerable people. And so, we have kind of looked at being able to do a few people here and a few people there, and giving us an earmarked amount allows us to do that and to stop squabbling amongst ourselves as to how we are going to spend the money.

I have—maybe this is another right answer to the wrong question, but——

[Laughter.]

Ms. **James**. We have had such a focus on how much care management costs, that we have forgotten what our survey of needs says, that 80 percent of these people desperately want to stay at home. And it seems to me that that is 80 percent of the taxpayers, are saying please, government, help me stay at home. And why are we quibbling about this? This is not a heart transplant. This is $750, $900, $1,000 a year to stay at home.

And yet, we have been put in the position perhaps because we are the new kid on the block in terms of networks, in terms of defending it. And I think that is wrong that we have to defend it and cost it out to the extent—none of these things—I mean, transportation is not high-tech either. I&R is not high-tech either.

Mr. **Kleyps**. Providers, at least the ones that I know of, other directors, other service providing agencies, have historically done what needs to be done regardless of what the mandate to be done is.

We do not have clients that call up and say, hello, I'm 85 years old and I would like to talk to the IIIB social services director who coordinates chore service, homemaker and personal care. We have people that call in and say, I'm 85 years old, and I need somebody to help me wash my hair. And that is the bottom line. It was done on a grassroots level prior to the funding, on a very informal basis. A lot of informality still goes on within my agency.

Mr. **Kildee**. That's a giant step. Most of them wouldn't know where to call, or who to call.

Mr. **Kleyps**. It is. And the thing of it is the clients do not generally remember the name Trio Council on Aging or any other council on aging. They remember that my case worker Millie has gone out to their home three or four times in the past month whether it is to try and get them some medication or try and arrange for a doctor's appointment or try and get them to the hospital. They do not remember the agency.

The key is to try and get enough time at this point in time with the surging senior population to have that service provider be able to go in there two or three times, maybe, a month. In the instances of care management, it certainly is not beyond the realm of thinking of doing that two or three times a month, once a week even. Once a day would be an asset to a lot of these people. We just simply do not have that time to do that is the problem.

And I guess this is what I alluded to earlier with the opposition that I stated to raising the age limit. A lot of this stuff is being done by our volunteers. I have been director of Trio Council on Aging for about five years now, and in five years I have never signed a mileage voucher other than for the cost to go to that—excuse me—not a mileage voucher, but a pay voucher. Our volunteers take a 20 cent a mile stipend for using their vehicles and that is it. We have run the entire home delivered meal program from day one. We conceived our agency in 1974, and to my knowledge, I do not believe there ever has been a paycheck written to anyone to take a home delivered meal out. Just the mileage is involved. And I get to put in one plug for the Department of Defense. We sucker more people from Wurtsmith Air Force Base for home delivered meals on their own time. The 920th Air Refueling Squadron—God bless them—they have done it without even taking mileage money too. So, we do work with the local agencies and the local——

Mr. **Kildee**. It's just Cap Weinberger buying each for $21,000——

[Laughter.]

Mr. **Kildee**. Thirty-one cents worth of spare parts bought for $21,000 for the Pentagon. It's the top part I guess, but obviously that is part of your economic unit up there too—clientele.

I want to thank the witnesses. It has been a very good panel.

Yes, Joe?

Mr. **Benavidez**. You know one of the hardest things about transportation is that it is not in the Older Americans Act. When you talk about accessibility, there is not the monetary dollars there to make sure that those services that are in the Older Americans Act are going to be delivered. And until that changes or people have to make sure that there is enough in transportation—I know you people went through holy heck to make sure that the transportation that you came up with passed. But you have to keep an eye open and see what it is that is happening for the elderly in transportation because the Administration could care less about transportation. And he has been very adamant about that since he got into office. And I hope the same thing that was echoed on this last vote on the transportation bill will be continued as you look at services that pertain to the elderly.

Mr. **Kildee**. And there one dollars in that last bill for public transportation which we can hopefully translate into services for our elderly. I appreciate your comment, Joe.

Again, I want to thank this panel and thank all the witnesses today. Your testimony will be made part of the official record of these hearings. For those of you who are historians, the testimony will be bound and printed by the Government Printing Office.

And as a matter of fact, in case we do not have the wisdom to keep the peace in this country, which I hope we do, we have in the mountains of Maryland buried about a mile deep down in the mountains copies of transcripts. There will be copies of this buried down there. I hope historians will read and say, you know, a lot of wisdom was spoken there at that hearing in Flint, Michigan, a great deal of wisdom was spoken there. And I hope then that they will—as they go through congressional records, find that we have had both the wisdom and the courage to implement that wisdom. In that way, you have certainly touched history, and I hope that we will respond in a positive way to that.

I want to thank Congressman Sawyer for motoring up here to Flint. Let me tell you, it is asking a lot when you ask anyone to give up a good part of their weekend outside their district, because he does not have any precincts up here at all. I deeply appreciate that.

Mr. **Sawyer**. You mean I am not going to carry this room? [Laughter.]

Mr. **Kildee**. The hearing record will remain open for two additional weeks for additional testimony. And the hearing will be adjourned.

[Whereupon, at 5:15 p.m., the subcommittee was adjourned.]

REAUTHORIZATION OF THE OLDER AMERICANS ACT

Part 2

FRIDAY, APRIL 24, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Algona, IA.

The subcommittee met, pursuant to notice, at 11:30 a.m. in the meeting room, Algona Public Library, 210 North Phillips, Algona, Iowa, Hon. Fred Grandy presiding.

Present. Representatives Grandy and Tauke.

Staff present. Susan Wilhelm, staff director, and Carol Lamb, minority legislative associate.

Mr. **Grandy**. I think we will try to get started, and welcome you to this hearing on the Older Americans Act. I would like to first of all introduce my colleague who has graciously agreed to be here with me today, Tom Tauke, who I am sure you all know represents the second district in Iowa, and has been in Congress since 1978. In addition to many accomplishments, he has been a leader in the authorization, reauthorization and administration of the Older Americans Act, and he is the ranking Republican on the Human Resources Subcommittee of the Education and Labor Committee, which oversees the Older Americans Act. And I will have no problem saying publically that one of the reasons I wanted to serve on this subcommittee is because Tom Tauke is the ranking Member. And you find very quickly when you are a junior Member of Congress that if you serve with the right people, you learn a lot of the right things and you learn them a lot more quickly. So we are lucky to have him here today and I welcome you to Algona, Tom, and look forward to your comments.

I also want to thank the Chairman of the Human Resources Subcommittee, Mr. Dale Kildee, from Flint, Michigan, for agreeing to bring the Subcommittee to Algona to hear the testimony of the Area Agency on Aging Directors, and representatives from the United States Department of Agriculture, the Iowa State Department of Elder Affairs, in-home health care administrators, and most importantly, we have the Senior Citizens from the area for whom the program exists.

Ultimately, we are here to better understand the Older Americans Act from the point of view of the elderly; to gain insight into the various programs by looking at them through the eyes of their participants in Iowa.

When Congress passed the Older Americans Act in 1965, the goals were noble. They included everything from ensuring the physical and mental health of our elderly population to guaranteeing to the elderly the freedom of planning and managing their own lives to the maximum extent possible. The broad aim of the legislation was to design programs to meet the social needs peculiar to senior citizens.

Nutrition services, including the congregate and home-delivered meals, comprise the largest federally funded service under the act, growing from $100 million in 1973 when the nutrition program began, to over $600 million in the current year. This year an estimated 240 million meals will be served under this program. So approximately half of the funds appropriated under this act will go to providing nutritious meals for the elderly who might otherwise not receive the nutrition they require.

Another growing concern in our society, and particularly among the elderly, is the availability of adequate health care for those age 65 and over who experience chronic health problems, resulting in their dependency on others for care. The elderly, as a group, use a great proportion of our country's health care resources, and as public policy begins to unfold to address the demands of this growing population, health care for the elderly is going to assume a top priority. The mid-20th century baby boom will soon become the senior boom of the 21st century. So now is the time to begin planning for the demands we will soon face. And I look forward to hearing the proposals of the health care professionals that we have on our panels today.

Because of its high elderly population, Iowa has a particularly important stake in the reauthorization of the Older Americans Act. I look forward to the testimony of the witnesses before us today, and to taking this testimony back to Washington so that the needs of Iowans will be fully understood.

I would say in passing, this is a particularly opportune time for this hearing. We have just marked this bill up in Subcommittee and now will be taking it to the full Committee. So if ideas emerge here today, it is possible that we might be able to include them as amendments to the bill.

On that note, I want to turn the microphone over to my distinguished colleague from Dubuque, Congressman Tom Tauke.

Mr. TAUKE. Thank you very much, Fred. And I see we are getting the official gavel.

Mr. GRANDY. This is my first gavel, so please be kind.

Mr. TAUKE. Now we can be truly official.

Mr. GRANDY. Right.

Mr. TAUKE. It is very good to be here in Algona this morning. I should tell you before the hearing begins that Fred and I were on the floor of the House until sometime after 2 a.m. this morning, and so the night was very short, since we had to get up very early to be able to fly out here. Consequently, we are calling upon all the witnesses to be very interesting in order to be able to keep our attention.

This is a hearing of the Subcommittee on Human Resources, and I am very pleased to have the opportunity to serve with Fred Grandy on that Subcommittee and to join him today for this hearing. Fred has demonstrated an amazing mastering of the issues that are contained in the Older Americans Act, considering that he has arrived relatively recently in the Halls of Congress. And it has been very good to work with him on the concerns, particularly, of the rural elderly, which I am sure will be a topic of discussion today.

The Subcommittee on Human Resources has held six hearings now on the reauthorization of the Older Americans Act. Three of those were held in Washington, one in Montpelier, Vermont, one in Flint, Michigan, and now this one in Algona, Iowa. The actual consideration of this legislation, I suppose could be compared to something like a boxing match. It is not that we fight among ourselves that much, but it is that we do have rounds. Round one was yesterday, when we considered the bill in the Subcommittee on Human Resources. And we, in consideration of the measure, basically, I think, decided that we wanted to maintain and strengthen all of the existing programs contained in the Older Americans Act. We wanted, also, to look at some new ideas that might expand those services in some areas. We wanted to provide as much flexibility as possible to the states and to the area agencies on aging in the administration of the act, so that those agencies can respond to the unique needs of the people whom they serve.

The second round of the match will be held May 12, when the full Education and Labor Committee considers the bill, and we consider further amendments.

A number of issues were left hanging yesterday when the subcommittee concluded its consideration, that are going to be the subject of continued discussion at this hearing and at meetings in Washington, as we attempt to complete action on this legislation.

Then, assuming that the full Committee approves the legislation on May 12, the third round will take place later this Spring or early Summer, when the full House of Representatives will consider the legislation. It is our hope that by that time we will have reached a virtual consensus on all of the major issues. And we will have fairly clear sailing by the time we get to the floor of the House.

I know that there is broad support in Congress for this legislation and these programs, and so if we can iron out some of our differences relating to administration, apportionment of funds, and those kinds of things, I think we can have clear sailing in the House. Then, of course, we have the Senate to worry about, but we will let Senator Grassley and Senator Harkin take care of that side of it.

H.R. 1451, which is the number of the bill that we are considering, maintains the existing structure of service delivery under the Older Americans Act. The aging network that has developed over the 22-year life of the act will not change significantly with the passage of this legislation.

As I indicated, we have attempted to strengthen and improve the Act, maintain sufficient state and local flexibility, to ensure that those who are on the front lines are able to respond to unique needs in given areas.

One provision of the act that we approved yesterday, that I would like to draw particular attention to, is the establishment of a new Part D under Title III, which authorizes $25 million for in-home services to the frail elderly. This section was put together, largely, by Chairman Kildee of the Subcommittee, and it is a new part that is designed to meet the tremendous demand for services to the frail elderly who are homebound. I strongly support this initiative by the Chairman of the Subcommittee, as does my colleague, Mr. Grandy. And we believe that it is a very important step in meeting some of the needs of the elderly, particularly in some of the rural areas of the country, where some of our citizens are homebound. We think this is an appropriate addition to the array of services being offered under the Older Americans Act.

In any event, we are anxious to hear from all of you who are witnesses here this morning. And I, again, appreciate the chance to be here in Algona and the opportunity to work with my friend, Fred Grandy, on these important issues.

Mr. GRANDY. Thank you, Tom. And I would just say that the Congressman shows enormous courage in allowing me to chair the meeting. This is an absolute violation of House protocol, but as you can see, we do not necessarily do things according to the book in Iowa.

Mr. TAUKE. Well, let me just say that there is a method to my madness. If some of you go on talking 10, 15, 25, 30 minutes, I do not want to have to cut you off. I thought I would let your local Congressman do that.

Mr. GRANDY. Well, in that case, I will defer to my senior colleague.

We will now ask the first panel to come up. We have with us today on the first panel, Mr. Greg Anliker, who is the Director of the Iowa Lakes Area Agency on Aging, located in Spencer. We have, all the way from Sioux City, Mr. Rich Motz, who is the Director of Area 4, Agency on Aging, which represents Woodbury and Plymouth County. Mr. Vince Weber, from the State Department of Elder Affairs is here. We have Ms. Sarah Huber—is it Huber? Huber. I am sorry, from Senator Harkin's staff, and also Mr. Tony Accurso, who is with the Elderbridge Mason City Area Agency.

So, if we could ask you folks to come up, and take your name tags with you. The only thing we will try to observe is if you have written statements and want to summarize, please feel free to do so. Everything that we say here today will be transcribed and placed into the record, so if you want to make brief remarks and not read your entire text, that is perfectly okay, and we will have questions afterwards.

I think what we will do is to just ask you all to make a statement if you choose, and then Congressman Tauke and I will proceed with questions.

In the interest of time, Mr. Accurso, I know you had a time problem. So, if nobody objects, why do we not just go right down the panel, starting with you.

STATEMENT OF TONY ACCURSO, ELDERBRIDGE MASON CITY AREA AGENCY ON AGING

Mr. ACCURSO. By way of introduction, I am a board member of the Elderbridge Agency on Aging located in Mason City. I am from

Bancroft, and I represent Sioux County. I have been on the Board for 4 years.

I will try to make this brief. My first knowledge of the Older Americans Act is when I turned age 60. My wife said, Tony, why do you not go with me up to the congregate meeting? My first impression was, Lois, you are not going to get me to go up and meet with those old people.

Well, since then, I have found there are two outstanding things that happen at these meal sites. One is that you get a very nutritious meal that is really a planned program. And the second thing is that it is a good social atmosphere. These people really enjoy going up there and eating and socializing. And I feel the greatest benefit is the social atmosphere. It is a tremendous thing for these older people to have a place to go. The federal program has created these senior centers, and you will notice there is a senior center in just about every city, so it is pretty well organized. My wife will go up in the afternoon and play cards, and I usually go golfing if the weather is right. But otherwise, I play cards up there, too.

One of the other programs that we have in the county is a well-elderly clinic. And I will not talk too much about that, other than it is a very fine program that has been well received, and these older people do need these physical assessments, because many of them do not feel like going to a doctor for one reason or another.

Being on the board, I feel that the Older Americans Act is being well-served by our area on—agency areas. I support providing these services by the agencies. It has been said that possibly the state may take over in handling the services, and I feel they can be better done on a local basis as these agencies have been doing. Being on the board for four years, I have found that we have very capable people who are handling these federal funds. Not only are they capable, they are very knowledgeable, they are caring people. They care for these elderly people, and I cannot see where it can be improved on by handling it from the State of Iowa.

Regarding legal services, I understand there is a proposal to use six percent of the funds from these services. It appears to me, from the experience that I have had, that this is not necessary to expend this six percent. I think it is being done on a local basis without necessary expenditure.

A couple of other items, and then I will try to make it brief. There is a proposal to raise the Federal funds for administration use from 8½ to about 11 percent. And this would be helpful, because there are so many programs that the agency has to provide, such as Alzheimer's disease, and others, where we have no funds. And if this was raised, I believe it would be helpful.

It appears to me that the Older Americans Act has been doing a good job, and I would recommend that it continues. And I do not see the need of too many big changes, but I do like to emphasize that the people involved have done a very good job.

Thank you very much.

Mr. Grandy. Thank you, Mr. Accurso. Can you remain for some questioning?

Mr. Accurso. Sure.

Mr. Grandy. Then I will ask Ms. Huber to make her statement.

STATEMENT OF HON. TOM HARKIN, A U.S. SENATOR FROM THE STATE OF IOWA, READ BY SARAH HUBER, STAFF ASSISTANT

Ms. HUBER. Senator Harkin was sorry he could not be here today, but he asked me to read a summary of his statement that he submitted to the Committee.

Mr. Chairman, I commend you for selecting Iowa as a site of one of your field hearings for the Reauthorization of the Older Americans Act. The number of older Americans is increasing and their needs are changing, but, interestingly demographers have shown us that conditions affecting older Americans are different in various regions of the country. I am extremely pleased that this opportunity has been created to obtain direct testimony from Iowans. In my capacity as a member of the Committee on Labor and Human Resources, which has jurisdiction over the Older Americans Act, you can be assured that I will pay careful attention to the testimony and records of the hearing.

We are experiencing a period of rapidly changing demographics. The elderly population has grown more rapidly in this century than has the rest of the population. Persons 85 years of age and older are now the fastest growing age group. This has significant implications for continued and expanded support for services authorized and funded under the Older Americans Act and other services coordinated through the act.

Older Americans face a wide range of significant issues in such areas as economics, health and civil rights. For example, we must maintain a quality health care system which is fully accessible and at a reasonable cost. To this end, cuts in Medicare and Medicaid that threaten the quality and accessibility of needed health care cannot be tolerated.

There are many areas which must be examined with legislative and regulatory changes in mind that impact the lives of elderly and disabled Americans. Although they cannot be fully resolved in the reauthorization of the Older Americans Act, this act is an important component of a national approach to improving the lives of older persons. Though the elderly may receive services under a multiplicity of other Federal programs, the act is a major vehicle for the organization and delivery of services to older Americans.

The areas I believe need to be addressed and considered in the reauthorization of the Older Americans Act include the following:

1. Services will need to be continued and expanded to meet the changing needs and size of our older population. Increased funding for all Titles is needed due to the growth of the aging population.

2. Serious study and possible solutions are needed to meet the problem of individuals being discharged earlier and sicker from the hospital, and requiring services at home, or to maintain themselves at home without having to resort to a nursing home due to a lack of services.

3. A stronger expanded role for the long-term care ombudsman program deserves careful consideration so that we might provide greater legal recourse for those elderly citizens in need of it.

4. As Chairman of the Subcommittee on the Handicapped, I believe there should be serious evaluation of participation by the elderly disabled in the Title V Community Service Employment Pro-

gram. The disabled have not been readily considered in these programs for low income and unemployed persons, 55 and older.

There are also other issues for the elderly not covered under the Older Americans Act, but that are vitally important for the elderly, such as supplemental insurance, nursing home reform and adult day care. These issues should be considered over the next few months, and I will also carefully examine legislative initiatives and concerns from my constituents in order to provide more comprehensive and quality services to the elderly of Iowa and the nation.

I am confident that we can reach agreement to further improve this important legislation, and welcome the reflections, suggestions, and proposals of all Iowans on the act, and on the other issues facing older Americans.

Mr. **Grandy**. Thank you, Ms. Huber. Can you remain for questioning? Can you speak for the Senator?

Ms. **Huber**. Well, I have just been, basically, asked to read—our legislative assistant could not be here today, so—but I will——

Mr. **Grandy**. OK. Please thank the Senator for us, and we appreciate his participation even if he cannot be with us today.

I think it is worth noting that Iowa is very well represented in these matters, particularly on the Labor and Human Resources Committee in the Senate and on the Education and Labor Committe in the House. Senator Grassley has also served on that committee, so we have a fairly broad-based support in the Iowa delegation for these programs. Thank you.

Mr. Greg Anliker.

STATEMENT OF GREGORY L. ANLIKER, EXECUTIVE DIRECTOR, IOWA LAKES AREA AGENCY ON AGING, INC., SPENCER, IA

Mr. **Anliker**. Thank you, Congressman. I appreciate the opportunity to be here and the invitation to speak before you and the subcommittee. I would just like to share some of my perspectives, if I can, about the Older Americans Act.

As you know, it was originally passed back in 1965, and was really one of the earliest acts from a federal level that returned a substantial amount of the control and the decisionmaking regarding the operation of the programs back to people in the State and particularly in the local levels. The act, I believe, was built on the idea of local involvement and decisionmaking by the elderly to help meet needs of other elderly. And that occurred from the local level up to the state and eventually to the national level. I think this is an important point because it recognizes the needs and problems of the elderly and that they can vary, not only state by state, but area by area within a state.

Local flexibility and involvement by the elderly in the planning and operations of the programs and services under the act has been one of its landmarks and I believe, major reasons for the successes of the act. For example, in Iowa, over 20 percent of the total resources available to the Aging Network are in the form of cash contributions from the elderly themselves, for the services helped—partially funded under the act.

In the nine-county area of northwest Iowa covered by the Iowa Lakes Area Agency on Aging, nearly 28 percent of our total cash resources come from contributions from the elderly themselves. I think it is important, at least in our area, and I believe this is pretty much true throughout the midwest and probably the nation, that most elderly people are proud to support what they consider their programs and services with their personal funds. I believe it is that reason, at least in part, because they feel they are improving their community, helping their peers, and helping build an important program for future seniors.

The nearly $14½ million of elderly cash contributions in Iowa during fiscal year 1986 only tells part of the story, however, because based on a survey conducted by Iowa's 13 area agencies on aging back in April 1982, the value of the elderly volunteerism for their programs nearly matched their cash contributions. The result of that April, 1982, survey were that there, for one month, were 11,342 different volunteers that contributed over 83,000 hours of that service in that month. The value of that service, using only the value at minimum wage, was $279,483. When you project those figures out for a year, and we believe that April was a fairly representative typical month, the value of their time for a yearly basis was well in excess of $3,300,000.

Now, for area agencies on aging, they averaged 872 volunteers each agency during that month, and the median number of volunteers was 575.

Another point, just briefly, is that back in 1982, when this survey was conducted, there were 271 congregate meal sites in this state. Last year, during fiscal year 1986, there were 383, a growth of over 41 percent. Funding for that same period grew by slightly less than a third, and that included an increased contribution, cash contribution of about $700,000 by the elderly, again. If we can assume that similar growth in volunteerism occurred as did growth in the number of meal sites, that means that the value of their time in volunteerism now would be somewhere between $4.4 million and $4.7 million a year, just in minimum wage.

The importance of these facts, I believe, cannot be overestimated. The elderly involved with our program feel a strong degree of responsibility, and I think ownership for their programs and their agency. Many of the best volunteers and supporters are involved not so much for themselves, but to help others, because they often are people with moderate resources. And I believe that this is perhaps one of the best arguments for leaving the program as it has been, in that the programs and services under the act are available to any and all seniors, regardless of economic or social status. However, we do try to target those with special needs to utilize the programs to a higher degree, and I think we have had fair success in doing that, also.

Frankly, if it were not for all of these people involved, we would probably be serving far less needy older people as well. The need for these moderate income elderly, I believe, is an important need also, socially. Because those folks have reached retirement, and many of them have a need simply to be involved and to be helping other people.

It has taken a great deal of effort for the area agencies in this state, and I assume in other states, to develop the program in this somewhat representative manner. For example, I guess the point I am trying to make is if we did not have to be so open to older people, and I think it is important that we are, my job would be much easier. The same would be true of staff at the state and federal level if they did not have to prepare information and listen to the views and the needs and the problems and the wishes of older people, we could probably do our jobs much quicker and much easier. However, I do not think that doing your job quicker and easier is very often the best way to do it.

As the saying goes, anything worth doing is worth doing well. And in my view, doing it well means demonstrating through legislation, regulations and actions, that we really do believe that elderly people have a great deal of wisdom, experience and abilities which they are often willing and able to share for the benefit of their programs, their peers, their community and their country. Through our experience, working with the elderly as older workers, Advisory Council and board members, senior advocates and many other capacities, we know they bring to their communities and society much more than just the problems that we so often hear about. We can, and should, utilize them to help solve the many problems faced by the elderly.

It is for that reason that I urge you to consider very carefully in your deliberations at the subcommittee and at the committee level and on the floor, all changes that would make substantial changes in the area of mandating additional services or consolidating decision making to the state or national level.

I believe if any changes are to be made, they should be made in the interest of increasing the involvement of elderly in the decision making at all levels. In addition, service and funding priority should be, as much as possible, determined at the local level.

I was very pleased to hear in your preliminary statement that the subcommittee action has also now planned on including and incorporating a new Title IIID to help with the expenses related to home health care costs.

Those are my views and my thoughts, and I appreciate the opportunity to present them. Thank you.

[The prepared statement of Gregory L. Anliker follows:]

TESTIMONY

SUBMITTED TO THE

HOUSE EDUCATION AND LABOR, HUMAN RESOURCES SUBCOMMITTEE

APRIL 24, 1987

HEARING ON THE OLDER AMERICANS ACT

GREGORY L. ANLIKER

EXECUTIVE DIRECTOR, IOWA LAKES AREA AGENCY ON AGING, INC.

2 GRAND AVENUE, SPENCER, IOWA 51301

Congressman Grandy and Congressman Tauke:

Thank you for the invitation and opportunity to submit testimony to you regarding the Older Americans Act. I would like to share with you some of my perspectives regarding the Act.

The Older Americans Act, originally passed in 1965, was one of the earlier Federal acts to return a substantial amount of control and decision making regarding the operation of programs to the States and local people. The Act has been built on the idea of local involvement and decision making by the elderly to help meet needs of the elderly. The Act has always required that many funding decisions and plans for service be made in consultation with senior citizens, from the local level, up to the state level. This recognizes that needs and problems of the elderly can vary not only State by State, but area by area within a State.

Local flexibility and involvement by the elderly in the planning and operations of the programs and services under the Act has been one of the landmarks and I believe, major reasons for the successes of the Act. In Iowa, over 20% of the total resources available to the Aging Network are in the form of cash contributions from the elderly. Most contributions are from the congregate meals program. In the nine counties covered by Iowa Lakes Area Agency on Aging for which I serve as Executive Director, nearly 28% of our total cash budget is from the elderly.

Most elderly are proud to support their programs and services with their personal funds. I believe this is true at least in part, because they feel they are improving their communities, helping their peers and are building something important for future senior citizens. In Iowa, the nearly 4.5 million dollars of elderly cash contributions in Fiscal Year 1986, tell only part of the story. Based on a survey conducted by Iowas' 13 Area Agencies on Aging in April of 1982, the value of elderly volunteerism nearly matched their cash contributions.

The results of the survey were as follows:

1) 11,342 volunteers contributed 83,428 hours of service;
2) the value of the service for one month using only minimum wage was $279,483;
3) projecting that figure for the full year showed the elderly volunteerism valued at $3,353,806;
4) the average number of volunteers per area agency was 872, the median number of volunteers per area agency was 575.

In 1982, there were 271 congregate meal sites in our State. Last year there were 383, a growth of over 41%. Funding for the same period grew by slightly less than a third, including nearly $700,000 in increased cash contributions from the elderly. Assuming a similar growth in volunteerism through the new sites and the results of the previous survey, the value would now range between $4,460,563 and $4,728,866.

The importance of these facts cannot be over estimated. The elderly involved with our programs feel a strong degree of responsibiltiy and ownership for "their" programs and "their" agency. Many of our best volunteers and supporters are involved, not so much for themselves, but to help others, because they are often people with moderate resources. This is perhaps one of the best arguments for the idea that programs and services provided for under the Act, should continue to be available without regard to income or social status. Frankly, we would be providing far less service to "needy" elders were it not for the commitment in terms of time, money and expertise from those elders whose need is to be involved and helpful to others.

It has taken a great deal of effort to develop area agencies on aging in this representative manner. For example, my job would be much faster and easier if it were not necessary to gather and present facts to our elderly Advisory Council or our Board of Directors, for their action. Likewise, it would be easier for staff of the Iowa Department of Elder Affairs or the Federal Administration on Aging, to call all the shots and make their decisions without considering local concerns and differences. But the easier way is seldom the best way to do things.

As the saying goes, "Anything worth doing, is worth doing well." In my view, doing it well means demonstrating through legislation, regulations and actions, that we really do believe that elderly people have a great deal of wisdom; experience and abilities which they are often willing and able to share for the benefit of their programs, peers, community and country. Through our experience working with the elderly as older workers, Advisory Council and Board members, Senior Advocates and other capacities, we know they bring to our communities and society, much more than just the problems we so often hear about. We can and should utilize them to help solve the many problems faced by the elderly.

It is for that reason, that I urge you to consider very carefully any and all proposed changes, which will either mandate additional services or consolidate decision making and operational activities to the state or national level. I believe that if any such changes are to be made, they should be made in the interest of increasing the involvement by the elderly in decision making at all levels. In addition, service and funding priorities should be as much as possible, determined at the local level.

Thank you for considering my thoughts.

Respectfully submitted,

Gregory L. Anliker, Executive Director
Iowa Lakes Area Agency on Aging, Inc.

Mr. **Grandy**. Thank you very much, Mr. Anlicker, for an excellent statement, and I think a good example of how this program works out. For the record, would you mind just stating the counties that your area agency represents?

Mr. **Anliker**. Okay. Our area agency represents from the South Dakota line, Lyon and Sioux Counties, and then working east, Dickenson, Oceola, O'Brien, Clay, Univista, Emmett, and Palo Alto Counties.

Mr. **Grandy**. So Spencer, clearly, is your largest urban area?

Mr. **Anliker**. Yes. In fact, it is the only community we have over 10,000 population. We are a very, very rural area.

Mr. **Grandy**. So this is an example, I would have to say, of a rural area or agency. Are you reaching all of the counties, do you think, effectively?

Mr. **Anliker**. With most of our programs we have all services that we are able to fund available in all of the counties pretty much on an equal basis. We, of course, I think like everybody have needs that we have been unable to meet because of funding limitations, but I think most people are pleased with the services available through the various subcontractors that we work with.

Mr. **Grandy**. Thank you. I would like, now, to go to Mr. Rich Motz, who represents the Area Agency in Sioux City. I would just assume, at the outset, Mr. Motz, that you represent an urban area agency for the most part. Is that correct?

Mr. **Motz**. Yeah, technically we are.

Mr. **Grandy**. Okay.

Mr. **Motz**. Demographically, we have about 30,000 people in our five counties, which include Cherokee, Plymouth, Woodbury, Ida, and Minona Counties. Of that 30,000 people, just a little bit less than half live within Sioux City, and the balance of the area—well, the rest of the area is what you would characterize—I think what most people would think of as rural. Although I do have to admit there are a couple of communities, LeMars being one, that is not considered, technically, to be a rural community, although I think most of the people in LeMars might tell you differently.

Mr. **Grandy**. I will let you proceed with your statement, then.

STATEMENT OF RICH MOTZ, DIRECTOR, AREA FOUR, AGENCY ON AGING.

Mr. **Motz**. My statement will be much briefer and probably a little more rambling than Greg's. I will just try to point out a few things between the lines, so to speak, from my statement. Most of my comments are relative to what I have heard has been or will be proposed in reauthorization of the Older Americans Act, either through administration or various support agencies.

There is really three areas that I have some concern about. Before I express my concerns, I should say that I believe the Older Americans Act—I guess I would like to echo the comments of the others. I believe the Older Americans Act has very well fulfilled its mission as it was first intended to do. And if I had any suggestion or recommendation to make today, that as you deliberate reauthorization of the act, that your focus be on making good better.

And I tend to be somewhat conservative in my approach to services and one of the things that I think is very important as we progress is that we not forget what we have been and what we are to the people we are, and sacrifice some of those things for new programs and new services. I call it delution of mission. A fellow by the name of Rodney Leonard, who works for the community nutrition insititute, I read an article by him recently that talks a little bit about delution of mission as it relates to the nutrition program. I do not agree at all with his conclusions, or what he is attempting to support in that, but some of the statements he makes in support of his conclusion are right on, and I think if you ever have the opportunity to listen to him—I have never heard the man, just what I have read. I think he has something to say.

And with that in mind, I am a McDonald's graduate. I used to cook hamburgers. In fact, I had the distinction of cooking the first cryogenically frozen hamburger in Sioux City, Iowa.

Mr. **Grandy**. I am amazed the media was not alerted.

Mr. **Motz**. I have been accused—by the way, thank you for the nice weather today.

What I want to say, I want to make an analogy between our meals program and McDonalds. It is very simply, McDonalds is what it is because of the hamburger. Essentially what they did over the years is sold you a hamburger at cost, and hopefully you would buy those french fries and that Coke that went with it. And that is where they are going to make their money.

With Older Americans Act programs, we have provided a food service program for older persons nationally, and as Greg indicated, it has grown appreciably over the years. Today we are over 1,100 meals per day, and will be more next year if things keep going the way we are. The hamburger is our meals program. We are getting them there at our cost, and then we are letting people find services and companionship with peers, and also obtaining good, nutrition hopefully through our food service.

We have been able, over the years, I think, to expose a lot of people to a lot of good programs and services. I have heard expressed over the last few years, primarily through administration, that sort of thing, an attempt to introduce a social welfare model of providing services to the elderly, which I believe somewhat threatens the meals program.

I am probably not describing this very well, but essentially what is happening is people are drawn into our programs through the meal services, and then their exposure to other services is more or less self-directing. They determine what direction they are going to go, in terms of services, whether it be a homemaker program, or whatever.

You are hearing the words now, long-term care, channeling, all of that terminology. And that is very good. But my concern is we are also hearing talk of consolidation of the titles of the Older Americans Act.

My concern is, very simply, that I believe what is going to be happening in terms of strategy is that there will be some redirection of nutrition funds for other kinds of services, if some administration—or some strategies that I have heard discussed become implemented. That concerns me, because I believe the meals program is the cornerstone of everything we do, and it is important that it continue, in my mind.

Second, I have heard some discussion of cost sharing or means testing for the meals program. I have mixed feelings about that. I often consider my role as the minister of the church that has to pay the heat bills, or the utility bills, and make things happen, and we have basically the same kind of thing. We have the givers, and we have the givers. Now, whether it be an in-kind gift, or a cash gift. We have—the nature of our program is that we probably do have people that could contribute more if we went to a means test—at least some means test would suggest that perhaps they have the ability to give more. We also serve a substantial number of people who cannot give more—in fact, give more than they ought to be giving.

I am inclined to think that, perhaps, we have gotten this far with what we have done. We have been able to increase services without increasing revenues, well, substantially—without increasing revenues at a commensurate level, is probably the best way to say it. And I am inclined to think that perhaps continuation of present policy relative to older Americans contributing towards the programs as they are able to, is probably the best course, as we reauthorize the Older Americans Act.

The third thing, and I know this is of some interest to you, and that is my feelings about personal care services and in-home care. I would only say, there, that I have heard suggestions that area agencies on aging perhaps ought to become more influential in determining what is quality care, relative to the delivery of in-home care services. I do not know what it is like nationally in terms of the roles of area agencies on aging. I can only tell you in my area, the State of Iowa appropriates roughly a half million dollars for five counties for the provision of in-home care. They fund several subcontractors for the provision of service.

Our role is what I term to be secondary in that system, in that we do provide approximately $30,000 in additional funds for in-home care programming. That $30,000 supplements services in three counties. We just went through our funding process and interviewed several agencies. Of the five that provided services—or of the five counties in which services are provided, only three requested additional funding, or funding supplemental to the state funds.

I think more funds are needed, and I think we are in a transition phase. We are right now seeing the acute care industry health industries get into the business of providing home health care, or really going after that business, I think, and we are headed for some interesting times. My only concern relative to that services is that I think we need to be able to provide more service, and I think that, hopefully, case management will assure that people get the services they need. I am concerned whether or not it is appropriate for area agencies on aging to be involved in what determines quality care—whether we are the best entity to do that. That might be heresy with some of my counterparts, but that is my own feelings about that.

The only other thing I would say is I think one thing that has really developed for area agencies, and I am—if I am just allowed to brag for just one second, just this week, I have made referrals to an area agency on aging to Passaic County, New Jersey, and Orange County, California. The Passaic County, New Jersey was for an elderly—the son—the grandson, who was concerned about his grandfather in New Jersey who had Alzheimer's disease, and his Mom and Dad were having problems.

We do have some real problems with Alzheimer's disease, and I appreciate Congress' foresight in moving in that direction, and I think more needs to be done, particularly in the area of respite care, which is another facet of in-home care.

We also, by the way—the other border—we went from Orange County to Passaic County to McAllen, Texas, which is on the Rio Grande border. And I guess what I am saying is we truly have become a national network. People are seeing us, knowing about us, and beginning to use us. Now, if we can only get all 650 area agencies on aging to identify ourselves in the phone book as area agencies on aging, we have got it made.

Thank you for allowing me to talk, and with that, I will be quiet.

[The prepared statement of Rich Motz follows:]

PREPARED STATEMENT OF RICH MOTZ, DIRECTOR, AREA FOUR, AGENCY ON AGING

Thank you for the privilege of presenting testimony to the distinguished members of the Human Resources Subcommittee. The Older Americans Act is something I have been personally involved with for over ten years. For this reason, I welcome the opportunity to submit written testimony and discuss with you the reauthorization of the Older American's Act.

In demographic terms, our five county service area is typical or representative of most Iowa service areas. The senior community (60+ years) numbers approximately 33,000 of which about one-third are over seventy-five. Nearly two-thirds of the population are women and just over one out of 10 seniors are at or below poverty. A little less than half of all our seniors live within Sioux City (Pop. 82,000), Iowa.

The area agency engages in the usual type of service delivery program. We provide, or contract for, a variety of services including transportation, meals programs, chore services, in-home care and senior centers - to name a few. We estimate that we reach 5-10% of the area's senior population with our various programs.

I would like to share with the subcommittee my observations about reauthorization of the Older Americans Act.

First, the Older Americans Act should be re-authorized and, in my opinion, "reborn". It seems as though there is a conscious effort to change the major focus or service delivery strategy of

Older Americans Act programming. For twenty years, our nation has provided a nutrition program that has served as a cornerstone for Aging programming. What we've essentially done over the years is develop a comprehensive program that attracts seniors through provision of a food service and then, while seniors are there, offer the company of their peers and provide information and/or access to other important social service programs. I am now hearing administrative decision-makers suggest that a social welfare service delivery strategy needs to be implemented to assure delivery of services to those "most in need". This strategy directs clients to services as determined necessary by a case manager--as opposed to the present strategy which encourages seniors to be self-directing.

A policy has been proposed that threatens, in my opinion, our Aging mission. The Fiscal Year 1987 Administration on Aging Legislative proposal suggests that Older Americans Act Titles IIIB, C-1 and C-2 be consolidated. I belive this would be a mistake. Given the present position of decision-makers in the Administration on Aging, it would only be a matter of time before funds for nutrition programs would be shifted to social service programming.

Second, cost-sharing or means testing is being suggested as a solution for meeting increased demand for services at a time when federal dollars are shrinking. My feelings about this are mixed. On one hand, it is entirely possible that there is a significant number that could pay more as determined through a means test. On the other hand, there is no doubt that additional eligibility requirements will cause lower participation rates.

All things considered, the present method of "charging" for services through contributions as determined by the client seems most prudent--at least for essential or mandated services.

Third, each reauthorization process seems to identify new challenges or tasks for area agencies. Most recently, we have become involved with Alzheimer's Disease and Intergenerational activities. This year some organizations are proposing a more significant role for area agencies in the in-home care field. I would suggest that new roles for area agencies as determined by Congress are necessary and important. New roles should also be appropriate. I can tell you that in my area over $500,000 is spent annually for in-home care. Our area agency contributes $30,000 toward this effort. I question whether our area agency can appreciably impact in-home care programming when we are a "secondary" provider. I would respectfully suggest that you consider the appropriateness of this role when you question witnesses in support of this proposal.

Finally, I would like to conclude by saying that Older Americans Act programming has come a long way in twenty years. There will always be new challenges. "Old" goals should not be forsaken or changed without careful consideration of the consequences. In my opinion, we have done well in carrying out the will of the nation as expressed in the Older Americans Act. I would urge the subcommittee and full committee's support of the Older Americans Act.

Submitted by:
Richard Mroz, Director
SIMPCO Area Agency on Aging
Sioux City, Iowa

Mr. GRANDY. Thank you, Mr. Motz, for a good statement. We appreciate your comments.

Our last panelist is Mr. Vince Weber, who is testifying on behalf of the Iowa Department on Elder Affairs. Mr. Weber.

STATEMENT OF KAREN TYNES, IOWA STATE DEPARTMENT OF ELDER AFFAIRS READ BY VINCE WEBER.

Mr. WEBER. Thank you, Congressman. I will be reading a prepared statement by Karen Tynes, who is the Executive Director of the Iowa Department of Elder Affairs. Karen extends her thanks for this opportunity to comment to the subcommittee.

Before I start reading the statement, I would like to preface it with some of my own comments. I used to work at Burger King. [Laughter.]

Iowa's elder population of nearly 600,000 depends upon services provided under the Older Americans Act. Because the demographics of Iowa are changing so dramatically, I am proposing that during this reauthorization, changes be made to keep pace with our aging society.

During each reauthorization, there has been a great deal of discussion about targeting funds for specific services. I feel that the states are in the best position to determine which services to fund and to what extent. Services funded under the Older Americans Act should be provided as a complement to services provided by such sources as the Mental Health Block Grant, Social Services Block Grant, Alcohol, Drug Abuse, and other state administrative programs.

The act should continue to allow states discretion in targetting funds. Iowa will continue to focus its resources on those with the greatest needs; the rural, the low-income, minorities, and very odd elders of our state. With the aging of our elder population and the increased needs that accompany the aging process, I feel it is time that states be given the latitude to apply cost—client cost sharing scales to some services, with the exclusion of advocacy, information and referral, outreach, ombudsman, protective services and case management.

At the same time, Iowa's Congressional delegation should oppose any federal budget cuts or statutory changes that would reduce resources or affect the ability of the Older Americans Act network to maintain services to elders for whom the act was designed.

States need flexibility to match funds for services provided under the act to local needs. The current authority to transfer up to 30 percent of Title III funds gives us that flexibility. As the advocate for Iowa's elders, the Iowa Department of Elder Affairs is in the best position to determine, through its interaction with other department of the Executive branch in which area additional planning, policy development, priority setting and evaluation of aging programs is necessary. These activities should not be directed from Washington, D.C.

The federal government should play a stronger role in affecting the administration of older worker programs. Although Iowa is one of the first states to develop a statewide equitable distribution plan with the three national contractors serving Iowa, there is an increasing need to see that those programs funded under Title V of the Older Americans Act are better coordinated with the Job Training Partnership Act. Stronger language in the reauthorization of the Older Americans Act would provide a base from which the state units on aging could build a stronger and more effective older workers program.

Iowa leads the nation with the percent of its population age 85 and older. The report of a Task Force that I appointed to study long-term care in Iowa identified the need for a coordinated and comprehensive continuum of care for Iowans of all ages. The missing links continue to be assessment and case management. I agree with the Administration on Aging that a comprehensive assessment and care management program funded by the area agencies on aging should not duplicate case management by other funded agencies.

It should be the role of area agencies to act as the focal point and advocate for older people to facilitate their movement from one care setting to another; not merely to promote an independent lifestyle. Area agencies on aging should help coordinate community based services to elders in their home, in hospitals, or in long-term care facilities.

A major commitment is required to sustain a community long-term care system. Both Medicare cutbacks and DRGs have had a dramatically negative impact on the health care needs of older people. States should have the primary responsibility to facilitate the coordination and integration of these community based long-term care services.

In 1971, the Iowa Legislature created the concept of Care Review Committees to serve as advocates for residents in long-term care facilities. Today, the Department of Elder Affairs appoints approximately 2,700 volunteers to serve on nearly 700 Care Review Committees. To date, the state legislature has not agreed to financially support these advocates through the ombudsman program. A recent study completed by Drake University in Des Moines funded through an Andrus Foundation Grant indicates that increased training and professional support is critical to the effectiveness of the Care Review Committees.

To increase the capacity of the ombudsman program, I support the addition of a Title IIID to the Older Americans Act to provide legislative authority for the state long-term care ombudsman and to provide for a separate appropriation. With the increase in the movement of residents from long-term care facilities to hospitals, the ombudsman must have the resources and flexibility to be the advocate for these residents. The addition of a Title IIID would provide both.

Thank you for an opportunity to testify today. I hope Iowa's comments will be incorporated into the reauthorization language.

Mr. **Grandy**. Thank you Mr. Weber, and thanks to all of the panelists. Mr. Accurso, can you remain for a while?

In that case, I will again break precedent in my new-found power as chairman of this ad hoc hearing, and allow the questioning to begin with my senior colleague from Iowa, Mr. Tauke.

Mr. **Tauke**. Thank you very much. And I want to thank each of the witnesses for their excellent testimony.

In the course of the discussions there was one issue that was raised that seemed to be one that could be rather easily resolved. That is this business of the phone book. What in the world is the problem that the area agencies on aging do not list as an area agency on aging?

Mr. **Motz.** It just does not happen. Some area agencies tend to identify—try to establish an identity with a name. For example, the area agency's, Elderbridge, Iowa Lakes Area Agency, or whatever. It is just my feeling—particularly now we are getting a lot more exposure in national magazines. Particularly, the last one—the most recently I read a magazine called Mature 50, and in it, it mentions this problem, and for some reason, I do not think nationally, by suggesting it, that it ought to be listed that way.

On the other hand, I might indicate—in Greg's area, I know, he has a tremendous amount of exposure. He might be better off calling it the Iowa Lakes Area Agency—he probably is. But it is just a personal feeling that nationally——

Mr. **Tauke.** Could it not be both ways?

Mr. **Motz.** I think it——

Mr. **Tauke.** If we talked to the phone company——

Mr. **Motz.** I imagine the phone company would accommodate that, yeah. It just seems to be something that if we could just nationally mention that it would happen.

Mr. **Motz.** Let me just run through a series of issues that arose yesterday.

First, on the costs issue which someone raised. The suggestion was made that we go from 8½ to 11 percent. Yesterday we tentatively concluded 10 percent would be an appropriate ceiling on administrative costs. Does anybody have any observations they would care to share on that?

Yes. Maybe you could tell us what your administrative costs are now.

Mr. **Anliker.** We have——

Mr. **Tauke.** You can pass the microphones down.

Mr. **Anliker.** In our area, and of course, this is speaking only for our nine-county area, because I do not know what the administrative costs of other agencies have been. Ours has been running around 6 to 8 percent in the last 2 or 3 years. I think the problem when we talk about administrative costs is maybe I budget slightly different than Rick's area, or so forth and so on. And what we consider administration could—is not well-defined. I do not believe there has been a serious problem with the 8½ percent. I would love to see the flexibility if it was allowed to go to 10 percent, because we are getting many more demands that are being interpreted as administrative—the Alzheimer's support type activities. Some of the stuff trying to get more done with legal services, and so on and so forth. It all ends up being administrative burden and we never have enough dollars for that. So, as more and more requirements or different mandates are put on us, maybe that additional administrative money is important, but I do not really, personally think it has been a big problem where it is at.

Mr. **Tauke.** Go ahead.

Mr. **Motz.** Our budget, administratively, runs right around ten percent——

Mr. **Tauke**. How do you get by with that now?

Mr. **Motz**. Pardon me?

Mr. **Tauke**. How do you get by with that?

Mr. **Motz**. Oh, excuse me. That is overall.

Mr. **Tauke**. OK.

Mr. **Motz**. Now, I need to define that. The way our plans are written—how do I do this Greg? We have area plan admen, and planning and development and coordination are the two areas. Area planning administration, by definition, is considered administration, and that is myself and all costs associated with me, and me only.

Mr. **Anliker**. And your board.

Mr. **Motz**. Well, yeah. Planning development and coordination is considered a service cost, and that involves the remainder of my staff, which is three professional persons, and their costs associated with them. That is not considered in that 8.5 percent.

So, I probably should not say this. I am going to get in trouble. But as far as I am concerned, it is a game. To be very honest, 8.5—where I am spending more than 8.5 for administration, I will admit it. Our budget is about 1.2 million. And if you ask how much you pay in for the people that sit in your office, Rick Motz, it is going to come out to right around $100,000.

Mr. **Tauke**. Is that typical of area agencies from your knowledge?

Mr. **Motz**. It is typical in Iowa, because that is the way we are all told to develop our area plans. I would be more than happy to provide you with a copy of the document, and I will test you one week after you receive it to see if you understand what it says. [Laughter.]

Frankly, it is a common complaint of mine that when I have to go out and make public presentation using documents that are used—or encouraged to be used, they are great for bureaucrats—talking to bureaucrats, but they are not great for bureaucrats talking to the good people we serve. And to Congressmen.

Mr. **Tauke**. We get fairly good at the bureaucracy.

Mr. **Motz**. I am not trying to question. I will send it to you, though.

Mr. **Tauke**. That would be very helpful.

Mr. **Anliker**. What Rick is saying is exactly what I meant by there is a difference in how you define administrative costs. When I go out and make presentations, for example, to the county boards and supervisors on what we have accomplished during the past year, I specifically point out, this is technically what administration is, but most people would include this and this and this in it also. When we include all of what I consider really most people would say is administrative, we have approximately 11 percent administrative cost. So, the definition that you are using can change, I think, not only from agency to agency, but state to state also. And I am not sure what definition you gentlemen use.

Mr. **Tauke**. I think we will look into that a little more and find out, precisely.

The legal services question. Yesterday, we had a very lengthy debate over a special set aside for legal services, was one proposal. Secondly, a requirement that every area agency spend at least as much on legal services in the coming year as it spent in the last year, so there could not be any quote "backsliding."

From what I have heard from the testimony here, I gather that you would prefer not to have that kind of requirement for expenditures on legal services. Mr. Weber, I note that you head the legal services division for the state. From your perspective, do you think, (a) that the area agencies are doing what they should be doing with legal services; and (b) do you think it is necessary for us to impose some kind of mandatory funding requirement for legal services?

Mr. **WEBER**. Well, Congressman, I am not really authorized to speak as a policy-maker with the Department of Elder Affairs. I would tend to personal opinion, I have been on the job five years now—I would tend to leave it up to the area aging agencies to fit the legal services requirement into their budget as they see fit. I guess I have observed the area aging agencies doing the best that they can at the local level trying to develop legal services program, and I would like to see that effort continuing. I think requiring a certain level of funding probably would not—in my personal opinion, would not be a good idea.

Mr. **TAUKE**. Does anybody differ with that?

[No response.]

Mr. **TAUKE**. Another item that is quite controversial is this cost sharing, or fees for service issue. There seemed to be some mixed emotions on the panel. We have had the American Association of Retired Persons, the National Association of State Units on Aging, the Governor's Association, the National Center on Black Aging, and various other groups and organizations suggest that we implement some type of limited cost sharing program, with the proceeds going to outreach services for those who are not being served at the present time. Would anybody care to offer any observations on that kind of proposal?

Mr. **ANLIKER**. I will.

Mr. **TAUKE**. OK.

Mr. **ANLIKER**. I think the idea of cost sharing probably is something we must move toward, because we know that a lot of people that are using the services funded under the act do have some resources. We also know that Congress, despite their efforts to provide adequate funding, we do have a deficit problem in this Country, and we are probably not going to get the funds we really need to serve all the people that we think have needs or that we ask for service.

If we were to be able to handle it carefully, and with as much local flexibility as possible, I think it is a direction that is good. And I guess what I would like to see if they move in that direction is that we do it somewhat similar to how the meal program contributions are operated, but maybe we add a little more information.

For example, at our meal sites, at every site we have a sign that says the actual cost of this meal is $2.50 or whatever it is at that particular site. And we track it site by site. We recommend a contribution of $1.50. That is one of the higher ones in the State of Iowa, and probably the highest in the nation.

Mr. **TAUKE**. What do you get on average?

Mr. **ANLIKER**. Our average contributions for the 6 months—first 6 months of this fiscal year was $1.48. So it is very, very good. And

I think it comes back to what I had in my testimony that we allow as much local decisionmaking in that meal-site as possible. Those people believe and feel and know that it is their program, and they will support it.

What I am suggesting with the cost sharing is that if we move slowly and very cautiously in that direction, maybe our sign could say, instead, if your income is under $5,000 a year, first of all, give the actual cost of the meal. I think that is important that people know what that is. And then say if your income is below $5,000 a year, we recommend that you contribute between zero and $1, or whatever. If your income is between $5,000 and $10,000, we suggest a $2 contribution. And if it is above $10,000 a year, we suggest full cost—$2.50, or whatever. But I do believe it is important, particularly for the meals program, that we continue to leave it as a suggested contribution, at ranges based upon their income.

And the reason I think it is so important to leave that meals program as a contribution, rather than a set fee, is because, as Rick was indicating in his testimony, that program is really the doorway to every other service that we are involved with.

Socially, it is probably, in my view, more important, even than nutritionally. Because it keeps people involved with their peers and with their communities, and I think that is very important. And it lets them know what is available as they age.

Mr. **Tauke**. What about other services? Do you think that contributions should be voluntary if you have a cost-sharing kind of program?

Mr. **Anliker**. I believe that that is the direction we should move. Again, very slowly and cautiously. In probably every service, leave it a contribution or suggested contribution, at least initially. And the reason I say initially, I think it is important that we phase this in, rather than just jumping into it, full bolt, because what we have found, even in our meal sites, is every time we increase the suggested contribution, we do lose a few. And the ones that we lose are the people that least can afford it. Most older people out there have a tremendous amount of pride, and if we suggest a buck and a half, even if they can only afford a dollar and a quarter, they are either probably going to give that buck and a half, or they are not going to come. So I think it is important that we be very, very cautious as we proceed in this direction.

On the other end of the scale, again, I want to reemphasize that a lot of the people that we serve in the meals program and the other programs do have some resources, and I think that they understand what the cost is, and it is helping support that program, most of them will give more than what they do now.

Mr. **Tauke**. Well, thank you very much for your excellent responses.

Mr. **Grandy**. Thank you. Mr. Accurso, I wonder if you could give us an idea of how the well elderly clinic functions at Elderbridge.

Mr. **Accurso**. Well, this is a program that is available for those over age 60 on a voluntary basis. These people have available what we call an assessment. It is more or less like a physical exam, but it is handled by a registered nurse, and the people have appointments made. For instance, at Bancroft, we have one coming Monday. We have four appointments. It is filled for the day. And the nurse will go through the appointment and ask several questions and make several assessments, as far as blood sugar, and just about a regular physical, but not like what a doctor would do.

If she finds anything through all of these tests, then it is recommended that these older people go see a doctor. And similar to what these gentlemen said, it is based on a contribution basis. There is no fee, but they will accept donations.

Mr. **Grandy**. Do you experience the same thing in Bancroft? For example, if you state a fee, do you tend to have people staying away from the examination?

Mr. **Accurso**. I think the answer would be to go slow like this gentleman said. In fact, I have been helping set up people to go to these clinics, and it has been received real well the way it is. I think if you would state a fee, that it might be different.

Mr. **Grandy**. Do you provide this service, do you go into the home and do this at all for people that perhaps cannot get to the center?

Mr. **Accurso**. Well, as far as I know, it comes to a certain location in the town. Maybe Mary could answer that. Would you go to a home, Mary, as far as——

Ms. **Kohler**. Generally, we do not make it a practice, just because there are some guidelines that the State Department of Health, that their planning facilities must be accessible, that we must provide for privacy. And the waiting room and the lab equipment that is necessary for us.

Mr. **Tauke**. For our recorder, could you identify yourself, Mary?

Ms. **Kahler**. Mary.

Mr. **Tauke**. Mary, and what is your last name?

Ms. **Kahler**. Mary Kahler, county public health nurse, K-A-H-L-E-R.

Mr. **Tauke**. Thank you, so much.

Mr. **Grandy**. I wanted to thank you, Tony. I wanted to get on to this business of fees and voluntary contributions, if you call them voluntary contributions.

Do you have any breakdown, either Mr. Motz or Mr. Anliker, on the difference between the contributions made at the congregate meal sites and those made to those people that distribute meals on wheels. It is much higher at the congregate meal site?

Mr. **Motz**. Yes. Our average contribution at a congregate meal site is approximately 93 cents per meal. That is area-wide. The range is actually anywhere from right around 50 cents to $1.05, I believe is our highest contribution. The home delivered meals program, the contribution is usually half of that, depending on the location.

Our largest program is a contract with the meals on wheels program in Sioux City. And their average contribution, right now, since we went to strict adherence on the contribution rule, has went downward. I believe it is between 40 and 50 cents, if I remember right.

Mr. **Grandy**. Let me explore that a minute. What is strict adherence to the contribution rule?

Mr. **Motz**. Well, what I am saying there is we have been associated or aligned with the program for 10 years. And a long time ago, I guess before it became C-1 and C-2, and now it is Title VII, there was a more, the suggested contribution was stronger—was more strongly suggested. [Laughter.]

Basically what I am saying is no person was ever denied service, but they basically said—there was that mentality of, here is what the cost is. And the staff—my staff has been working on making sure that that is better adhered to, in terms of that policy.

We have this old story about a small farming community, and they used to have a—well, I called it the lynching community that waited at the door for the farmer that had so many acres in that story. And the person had the ability to probably contribute more, but the law specifically states that they are not—that that is their decision.

And, frankly, once you sit down and explain to people the alternative is that every person sits down and indicates what their income is annually and goes through the usual bureaucratic thing, the alternative is much more palatible.

But I believe, probably more importantly, the home delivered meals contribution is a lesser amount, because I believe that we are probably, if we were to do a study of that, we would find out that the average income of those individuals is substantially less, whether it be due to more medical bills when they are in some sort of recovery period, or whatever. But their available income, usually in the home delivery program, is substantially less.

Mr. GRANDY. Well, am I safe in assuming that with the increasing number of people over 85 that are participating in these programs, are we not going to see an expansion of the home delivery—the Meals on Wheels Program? And it sounds like what you are saying, to a large extent, the congregate meal program is probably going to subsidize a lot of that cost. Is that correct?

Mr. MOTZ. The congregate program is subsidizing the home delivery program right now. We receive approximately $250,000 in congregate—federal congregate funds. We receive approximately $50,000 in home delivered funds. For that money, we will serve, this year, about 200,000 meals. If I get more than ten numbers in my head at one time, I am in trouble.

Mr. GRANDY. You ought to see it from our side.

Mr. MOTZ. Home delivered meals will serve about 70,000 this year. The reality of it, and I suspect Jean might be able to address this later on, but I suspect the reality is in most areas right now there is some sort of subsidy from the congregates right now towards the home delivery.

Mr. GRANDY. For the record, Tony, do you have an idea of how much it costs for a voluntary contribution at your meal site?

Mr. ACCURSO. How much it costs?

Mr. GRANDY. Yes, the average contribution.

Mr. ACCURSO. For the meal site?

Mr. GRANDY. Yes.

Mr. ACCURSO. I have no idea, other than I would guess $1.05.

Mr. GRANDY. That would be the average contribution?

Mr. ACCURSO. I am guessing.

Mr. GRANDY. Thank you very much.

Mr. ACCURSO. If you do not mind, I would like to be excused. And thank you very much, both of you Congressmen for holding this hearing.

Mr. **Grandy**. Thank you for your participation.

I just have one more question for this panel. And that is to you, Mr. Weber. We were talking a little bit about the cooperation between the Older Americans Act and the Job Partnership Training Act. Under Title V, according to my figures, you had about 61,000 job slots supported under the Older Americans Act for 1986, 1987. Do you have any figures for Iowa?

Mr. **Weber**. I do not—I am not prepared to give those now. I will see that they are forwarded.

Mr. **Grandy**. Could you provide those to the Subcommittee, because that would be helpful.

Mr. **Weber**. Sure.

Mr. **Grandy**. It says here that enrollees are paid no less than the federal or state minimum wage, or the local prevailing rate of pay for similar employment and work in a wide variety of community service activities. Do you have any idea of what that prevailing rate may be? How does that vary?

Mr. **Weber**. A similar type of thing. I am not prepared—I am not that familiar with that area. We will provide that.

Mr. **Grandy**. Sure. Go ahead, Richard.

Mr. **Motz**. We operate C-set programs. There happens to be three national contractors that work in my service area. It is a classic case of duplication. But anyway, the prevailing wage rate in our case is we allow the host agency to determine that. Generally, it is in the range of $3.35 to $3.75 an hour, depending upon the type of work that is being done.

We have, in our area, there is approximately—there was approximately a hundred and some slots. And due to equitable distribution in Iowa, we have lost some of those slots from our area.

Mr. **Grandy**. Do you have any comments on this, Mr. Anliker, as to what the wage might be in your area?

Mr. **Anliker**. Ours would be very similar to that.

Mr. **Grandy**. So it is close to the national minimum wage of $3.30. And the employers are providing that to people in the community?

Mr. **Anliker**. Actually, Oh—you mean is that the standard rate in the community?

Mr. **Grandy**. Yes.

Mr. **Anliker**. I think in some cases, the types of jobs that these folks generally get into, I think it is a comparable wage with the community rate for that type of job.

Mr. **Grandy**. Let me ask you this, in a matter of speculation. One of the other pervues for the Education and Labor Committee will be of course, to oversee a possible raise in the minimum wage this year. If that went into place, if there was an increase in the minimum wage, without any kind of dispensation to an employer to perhaps have a subminimum wage for this elderly work force, do you see that as a potential disincentive to participate in a program to provide job slots for elder Americans?

Mr. **Anliker**. If there was a subminimum wage for the elderly?

Mr. **Grandy**. If there was some kind of subscale. I do not know what it would be. But let us say for arguments sake that it is below whatever the new minimum wage would be.

Mr. **Anliker**. I do not believe that it would be a major disincentive for the people that are entering into this program. It is strictly a program for low income elderly. It is intended to be a training opportunity to get them back into the work force. I guess I personally feel that there should not be a subminimum wage, because in our agency, for example, over 60 percent of our employees that cook, and run the meal sites, and do stuff in our central office, over 60 percent of them are older workers. And quite frankly, I would put them up against any worker, any time, as far as their dedication and their willingness to work. Their attendance at the job. They are terrific workers. And I do not think they are worth less. In fact, they are probably worth more.

Mr. **Grandy**. I want to thank all of you for your participation on this panel.

Mr. **Tauke**. I just have one more question relating to Title III monies. How much transfer of Title III monies do we have in your agencies now?

Mr. **Anliker**. For Iowa Lakes Area on Aging, I think we have never transferred any funds. I think the current transfer policy is quite generous. I understand that the subcommittee looked at allowing 30 percent, but restricting a 15 percent in any one title. That seems to make sense to me. The proposal to raise it eventually to 75 percent—I believe that is what it was—or 50 percent. Whatever, I could never see the reasoning, at least from our perspective. Maybe there are reasons in other parts of the country. There is not in ours.

Mr. **Motz**. Our present budget—we have transferred $5,000 from the nutrition side into the general program side, and it specifically is going towards transportation of—at a Native American site to the meal site. This year, though, we are changing that. There will be no transfer of funds. We will still provide the service out of the general 3B allocations. So we do not transfer in that regard. We do transfer C-1 funds to C-2, the home delivered target.

Mr. **Grandy**. Do you have any more questions?

Mr. **Tauke**. No.

Mr. **Grandy**. Thanks to all of you for participating in this hearing. It has been very informative.

Our second panel with us today consists of four individuals.

We have with us Ms. Sonia Crow, who is the Associate Administrator of the Food and Nutrition Service at the Department of Agriculture. And with her, Mr. John Merz, the Director of the Mountain Plains Regional Office of the Food and Nutrition Service based in Denver. And also Mr. Chuck Ring of the Des Moines field office. Then we have Ms. Jean Beatty, is it?

Ms. **Beatty**. Beatty.

Mr. **Grandy**. I am sorry. Nutrition Director for the Area Agency on Aging of North Central Iowa, and Mr. Marvin Schlitzer, who is the Vice President of Swiss Valley Farms, Inc., in Davenport. If you folks could take a place on the panel here, we can begin with your testimony.

I might state for the record that Ms. Crow has already testified before this subcommittee and has certainly provided this particular member with welcome information on the use of the commodity programs and how they are used in the distribution of food services.

[Pause.]

Mr. **Grandy**. Why do we not start with you, Ms. Crow, if you have a statement, and then we will go to Ms. Beatty and then to Mr. Merz and Mr. Schlitzer.

STATEMENT OF SONIA CROW, ASSOCIATE ADMINISTRATOR, FOOD AND NUTRITION SERVICE, U.S. DEPARTMENT OF AGRICULTURE

Ms. **Crow**. Thank you, Mr. Chairman, Congressman Tauke, members of the audience. It is a pleasure for us at USDA to participate in this field hearing in Algona. It is a beautiful place, so I hope it is not my last time here.

In recognition of the size of the Chairman's gavel, and Congressman Tauke's admonition that we should at least try to be interesting, what I would like to do, with your permission, is submit my formal, prepared text for the record, and just spend a few brief moments summarizing an interesting part of that testimony, I hope, to all of you, and one that we consider very important at USDA.

We have many feeding programs at USDA, which are administered through my particular agency, which is the food and nutrition service. And Mr. Merz in our Denver office, and Mr. Ring in our local Des Moines office, assist us at USDA in administering those programs that basically serve people before they are born, all the way to our older Americans.

But the one program that we have at USDA that we administer through the nutrition program for the elderly is the one real program that is aimed specifically at providing nutrition assistance for senior Americans, and one that we consider a very important program. Our piece of the nutrition program for the elderly picture is basically limited to providing cash, or commodities in lieu of cash, in a per-meal reimbursement basis. But within this context, we have two very important initiatives this year at USDA that I would like to share with you.

The first one is a grant proposal. We are proposing that we change the per-meal reimbursement grant to a fixed grant. That is explained more fully in my testimony, and for those of you in the audience interested in the funding mechanisms, I hope you will read it and provide comments to your Congressman as to your positions on that, since members of this committee have been dealing with that issue now in Washington.

What I would like to focus on today in my comments is the second initiative at USDA, and that has to do with increasing the use of commodities in the NPE program. As I said earlier, we provide support in this program through two funding mechanisms. One is cash, and one is USDA commodities instead of cash. And when this program and USDA's involvement in the program first started, it was basically an outlet that we had for our price support surplus removal activities at USDA. This was a number of decades ago.

Over time, what has happened, as there has been more flexibility in the program to receive cash, states and local project sites have been electing to receive cash. So what we have now is a situation that under this program USDA provides about 96 percent of the funding, the reimbursement, in the form of cash, rather than in the form of USDA commodities.

And what we would like to see happen, is to reestablish the direct link that we had early on in this program, between providing nutrition assistance to our older Americans, and the link that we had with the farmers and with the farm economy. Because, as I said, our commodities that we provide, which we think are first rate, top rate, the best of the line, are through our price support and surplus removal activities. And we feel it is important to reestablish that connection. It helps our American farmers, which is important to all of us in this country—certainly important to the people in Iowa who receive a lot of support from those two programs, price support and surplus removal. And we think it is also good because we provide excellent commodities and nutrition assistance to elder Americans.

The commodities at USDA, as I said, are really first-rate. They are the best you can have in this country, not bargain basement commodities. But what they do provide is bargain basement prices. We have done a lot of studies on the use of commodities at USDA, and we have found out that in terms of the quality of what we provide, in terms of the cost delivered to your door, you can save, on the average 10 to 15 percent over cash, using commodities. On selected products, you can save up to 35 percent on the cost of purchasing those commodities with the cash we provide.

So we think it is very important for people to start looking more closely at the use of commodities in the NPE program.

One thing that we did last year to try to increase the use of commodities, was to reduce what we called our threshold for receiving bonus commodities. Those commodities that you can get basically free, that would not even be part of your reimbursement scheme. And before we had a system where you had to elect on a statewide basis 50 percent of your funding in the form of commodities, before you could get the use of these special commodities. We reduced that threshold last year to 20 percent. And a number of states have increased their use of commodities as a result so they can take advantage of the free ground beef, the free frozen cherries, the other excellent bonus commodities that we have.

Unfortunately, in Iowa, and I hope that those of you who help make these decisions can do something about it—the commodity usage when we reduced our threshold went down. It went down to 20 percent. It has been 28 percent the year before, so we hope that you will work a little bit harder on that and give us all the help that we certainly need.

We know that the use of commodities certainly, in a certain sense, does not give a state and a local project site as much flexibility as they think they might like. And that is why they—96 percent of the support we provide is in the form of cash. But we think there have been a lot of improvements in the way that USDA delivers its commodities to the people that use them. And we hope that you will take another look at that and certainly try to support the initiatives that we have.

We are currently funding the National Association of Local Projects Sponsors, NANASP Organization, which I think a number of you are familiar with, to go around the Country and put on seminars and try to encourage the increased use of commodities.

Secretary Lyng as established a task force at USDA and that task force is named specifically looking at commodity distribution, both internally within USDA and with all the important organizations with which we deal, including people within the NPE program, to try to improve it to the best possible way that we can so that it will be received in a timely fashion, and people will get a first-class product when they get it.

And so, Mr. Chairman, Congressman Tauke, the reason I am really here today is to pitch commodities. It is going to help the farmer, it is going to help all of us in this Country. It is certainly going to help the project sites make their dollars go a lot further. You were talking today about the importance of having a good funding base and the importance for voluntary contribution.

We hope that members of the Committee will keep in mind, when they are discussing funding issues, that we think at USDA the use of commodities is, in a sense, an untapped resource for you, since they do stretch the food dollar significantly, we think this is a hidden source of revenue and one that should not be overlooked, and you are going to be able to get more meals to more people at the same price if we start using the wonderful commodities that are available through USDA.

Thank you, Mr. Chairman, Congressman Tauke.

[The prepared statement of Sonia F. Crow follows:]

TESTIMONY OF SONIA F. CROW
ASSOCIATE ADMINISTRATOR
FOOD AND NUTRITION SERVICE
U.S. DEPARTMENT OF AGRICULTURE
BEFORE THE
EDUCATION AND LABOR COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
ALGONA, IOWA
APRIL 24, 1987

Thank you for your invitation to appear today in Algona, Congressman Grandy, to discuss the role played by USDA in contributing to the nutritional well - being of older Americans pursuant to the provisions of the Older Americans Act. I am pleased to be a part of this field hearing and will describe our efforts in this important area of program activity.

At the outset, I need to emphasize that the role USDA plays in the Nutrition Program for the Elderly (NPE) is limited solely to providing commodities or cash in lieu of commodities for meals served according to a set rate of reimbursement specified in the Older Americans Act.

The amount of food or cash that USDA gives each State is based on the number of meals served in the program and the level of assistance per meal authorized by legislation. USDA will be able to subsidize 241 million meals this year.

USDA has no involvement in operating or managing the Nutrition Program for the Elderly. It makes policy decisions only related to meal reimbursement. The Administration on Aging (AOA) of the Department of Health and Human Services (DHHS) holds the primary responsibility for this program and is in a more authoritative position to gauge results and successes. However, as funding is an important component of any program, I would like to turn now to USDA's role in the NPE.

When USDA first became involved with the Nutrition Program for the Elderly, the program was an outlet for surplus foods and price-support commodities, much like the school lunch program. As the years passed, however, legislation was modified to allow cash in lieu of commodities and gradually most States have chosen to receive subsidies in cash rather than in commodities. Today about 95 percent of our contribution is in the form of cash. (For this fiscal year, Iowa will receive 80% of its assistance in cash with the exception of "bonus" dairy commodities.) USDA is undertaking a number of activities to encourage the use of commodities in the program as we believe that higher quality meals can be served for a lower cost through commodity usage. Results from the Department's CASH-CLOC Commodity Study reveal that under the current commodity distribution system, school districts using commodities acquire 2 cents more per meal than in the alternative systems examined. Of course, through commodities, we help not only elderly meal service programs but also the nation's farmers.

Promoting Increased Use of Commodities

Last year, the Department announced a change in policy with respect to the availablility of bonus commodities to the NPE. Bonus commodities are those surplus and price-support commodities which the Department offers to a State at no cost for use in feeding programs. All States are eligible to receive bonus dairy products. Previously, only States electing to receive 50 percent of their NPE support in the form of commodities were eligible to receive bonus commodities in addition to dairy products. Under the Department's new policy, if a State agrees to take just 20 percent of its NPE support in the form of commodities, it may order the full range of bonus commodities, not just bonus dairy products. Such commodities currently include ground and canned beef, as well as flour and various fruit, vegetable and poultry items as they are available.

Since we reduced the threshold requirement in NPE the following new States have elected to receive 20 percent or more commodities thereby qualifying them for bonus items: Indiana, Arizona, Washington, Hawaii, and the Commonwealth of the Northern Mariana Islands. The States of Massachusetts, North Dakota, and Oregon increased their options to 20 percent or more. Eight States, including Iowa and the Trust Territories which were at the 20 percent or more level last year did not change. With the continued use of this reduced threshold policy, we are confident that we can expand elderly commodity usage even further.

As evidence of our commitment to increasing commodity usage in NPE, USDA is proposing to enter into an agreement with the National Association of Nutrition and Aging Services Programs (NANASP) to encourage elderly congregate feeding sites to use commodities. Under the agreement, NANASP will hold seven conferences across the country to demonstrate the quality and benefits of USDA commodities. We believe this effort will encourage providers to seek more commodities as they learn more about the benefits they get from using commodities.

Grant Proposal

Another important USDA initiative for NPE is the Administration's legislative proposal to simplify program funding through the use of a yearly grant. The funding problem created by the current per meal reimbursment rate procedure is best illustrated by the 1985 experience. In that year, the Department announced four different reimbursement rates. Obviously, confronted with funding uncertainties, providers were unable to properly plan their operations. Under a grant system, providers would know at the beginning of each fiscal year the amount of funding they would receive from USDA. A grant would allow providers to plan in advance and to manage their resources more effectively over the course of the year. The concept of a grant is nothing new to the States since other AOA programs are funded in this manner. USDA's proposal stipulates that all of this grant must be passed through to local agencies as meal support to ensure that the funds are not used for other Title III or VI programs.

A grant will not change the way that food is distributed at the local level, and providers will not need to change the way that they provide meals. Commodity usage flexibility will be maintained because States will still be able to obtain all or part of their grant in the form of commodities.

Conclusion

In conclusion, USDA is proud of its role in helping to meet the nutritional needs of older Americans under the Older Americans Act. We believe it is imperative that more commodities be utilized to merge the vital objectives of helping farmers and providing nutritious meals for the elderly, that a grant be instituted to simplify the program, and that we continue to strive to give the States the flexibility they need in obtaining commodities.

That concludes my remarks, Mr. Chairman. I shall be pleased to respond to any questions.

Mr **Grandy**. Thank you, Ms. Crow. Ms. Beatty, with your forebearance, I might ask Mr. Merz to go next, if he has a statement?

Mr. **Merz**. I have no statement.

Mr. **Grandy**. Fine. I just thought you might want to expand on what Ms. Crow said.

Ms. Beatty, do you want to go ahead, then?

STATEMENT OF JEAN BEATTY, NUTRITION DIRECTOR, AREA AGENCY ON AGING OF NORTH CENTRAL IOWA

Ms. **Beatty**. Yes. Thank you very much.

I manage a congregate meal program, which serves about 3,000 meals per day, 750,000 meals a year, stretched over 55 meal sites in 20 counties. I am here today to express support for the USDA donated food program. I hope that Congress continues to make the food option available to the nutrition program to the elderly, that we can be offered a greater variety of food, and that the USDA will lower their specifications for salt, sugar and fat in the processing of the foods we receive.

Let me briefly review the reasons that I believe that commodity foods are a vital resource to our primarily rural program.

The food quality is generally good. The system includes a distribution network for our area, allowing us to use it, rather than establishing our own warehousing and trucking network. Commodities allow us to use standardized menus, because of consistency of food available to all sites. Consistency of ingredients allows us to monitor quality of foods served. We can better judge the cook's performance, because the quality of the food is a constant.

Pricing of commodity foods is such that they represent excellent value. We could not purchase in our rural area equal amounts of food for the same dollars as we receive in our commodity entitlement. Our cooks have reduced purchasing responsibilities, which saves time and reduces mileage to larger communities for shopping.

Generally, there is a good variety of food products available. We currently have about 35 different products in our inventory. We greatly appreciated the addition of fish products, tuna and salmon, this past year.

Food is delivered earlier in the fiscal year than the cash in lieu of commodities, which is on a reimbursement basis. Food is obviously delivered before it is consumed. Cash is reimbursed months after the food is consumed. We believe the use of the commodities reduces cash flow problems.

Now, with all of the reasons we have for liking the USDA commodity food option, we currently elect to receive over half of our commodity entitlement in cash. We would order more food, but in order to do so, we must be offered greater variety of products. Over the years, we have noted that we have not necessarily been offered the same foods that are made available to the school lunch program or to the commodity supplemental food program. The NPEs would like to be offered products such as canned apples, grapes, grapefruit, tomato, or pineapple juices, evaporated milk, carrots, or dehydrated mashed potatoes. We have not been offered these foods, but they have been made available under the Commodities Supplemental Food Program, a pilot program for the elderly in Polk County.

We would like to be offered some products more consistently, such as purple plums, canned poultry, and canned beef, which have become rare treats. We note that some of the products we are offered are processed more to the liking of the school kids than the elderly.

For example, potatoes are processed into french fries, which may please the younger generation, but many elderly prefer their potatoes mashed. We do not object to USDA processing potatoes into french fries, but we would like to be offered the option of the dehydrated mashed potatoes. School kids may enjoy the chicken nuggets or fish nuggets, but we would probably not order those products for our dinners.

We would like to see pineapples and apples, for instance, offered as juice, as well as canned fruit.

In the processing of foods, we recommend that USDA change the specifications of processed food to reflect lower quantities of fat, sugar and sodium in the finished product. Since there is heightened awareness of good nutritional guidelines, we receive comments from the elderly themselves about the salty flavor of the canned vegetables, and the turkey roll, particularly. Lowering the sodium content of these products would be of benefit to all our diners, especially to those with hypertension. We particularly recommend that fruit be packed in their own juice, and that the USDA avoid packing fruits in heavy syrup.

I think the USDA commodities system is working better than it has in the 12 years that I have been involved in it. Some of the reasons for the improvement probably relate to the fact that we have improved our communications at the federal, the state, and the local levels. I think there is still some room for improvement in the system, and I believe that increasing the variety of foods offered to the MPEs and improving the nutritional quality of the processed food by reducing the salt sugar and fat content may encourage nutrition program directors to elect a higher ratio of food in their entitlement.

I thank you for giving me this opportunity to express my opinion.

Mr. GRANDY. Thank you, Ms. Beatty, for that very informative testimony. Mr. Schlitzer.

STATEMENT OF MARVIN SCHLITZER, VICE PRESIDENT, SWISS VALLEY FARMS, INC., DAVENPORT, IA

Mr. SCHLITZER. Congressman Grandy, Congressman Tauke, members of the panels, ladies and gentlemen, I am a dairy farmer member representing Swiss Valley Farms. And I appreciate this opportunity of presenting this statement here today.

And quite frankly, Congressman, I have to tell you when I first became aware that I was to make this presentation here today and participate on this panel, I wondered why. I guess after reviewing the list of panelists, I felt, quite frankly, that I was somewhat out of my field. And on top of that, I have never worked at McDonalds or Burger King, and never fried a hamburger in my life. [Laughter.]

But let me tell you who we are. I am going to give you a commercial now. But I just want you two folks to know who Swiss Valley Farms Company is. We are a processing, marketing and Farm Supply Cooperative, which is owned and operated by approximately 3,500 member owners. Our milk procurement area is eastern Iowa, southwest Wisconsin, northwest Illinois, southeast Minnesota and we have some producers in Missouri also. Our operation includes swiss cheese production at Luana, Iowa, cheddar cheese manufacturing at Hopkinton, Iowa, Ridgeway, Wisconsin, and Bangor, Wisconsin. We also have a bottling operation at Dubuque, Iowa, and Cedar Rapids, Iowa, drying plant at Maquoketa, and a commercial—a cultured—excuse me, a cultured dairy foods plant at Waterloo, Iowa. We process and market about 1.2 billion pounds of milk for our members yearly. We also have an Ag Service division headquartered at Monticello, Iowa.

And I guess my comments will be more from a broad perspective possibly, than some of the others here today as it relates to food assistance programs.

But Swiss Valley farmer members and I believe farmers in general across the nation, have long been supporters of feeding the truly needy and hungry people of our Country. And in a nation of such wealth and abundance as we have, certainly the health and nutrition of all our citizens should have high priority indeed. It seems ironic that our government-owned surplusses are regarded as a burden, when at the same time there is such a need. We, as farmers, have long been supportive of moving these commodities owned by the Commodity Credit Corporation out of warehouses where storage fees are increasing the cost of funding the U.S. Department of Agriculture.

I guess I am not in a position to make a judgment as to whether or not the legislation proposed by the Department of Agriculture to amend the Older Americans Act in methods of funding state-run agencies would result in improved nutritional programs. It seems, however, that in recent years much uncertainty and confusion existed, and that does not contribute to efficient administration within the states. It further seems that more nutritional assistance in the past was in the form of commodities and less in the form of cash than is the case presently.

I was shocked to learn, for example, that in recent testimony before your congressional committees, Congressmen, that it was stated that 95 percent of the nutritional assistance given by USDA to the states, is in the form of cash rather than commodities. And I believe you indicated, Ms. Crow, that it was 96 percent cash and 4 percent commodities. We would urge that this trend be reversed, and that the predominant share of food assistance be given in price supported commodities. And let me say perhaps not only price supported commodities. This would alleviate two problems: One, reduce storage cost incurred by the USDA, and two, ensure that individuals receiving food assistance would be getting a nutritional food product. I am sure that that is the intent of the food assistance program.

We are all, undoubtedly, aware that cheddar cheese, butter and dried milk are in distribution in food assistance programs. We would like to suggest that the fresh fluid milk be added to the list of dairy products used. I do not mean to imply that fresh fluid milk should replace dried milk, but become available in addition to the powdered form. I guess I mean by that become available in the same sense as powdered milk has been available. Dried milk does not have the advantage—does have the advantage of being stored and transported without refrigeration. It also used—it is used extensively in cooking and baking. Fresh milk, on the other hand, is perhaps a more convenient and acceptable product for people to consume.

If fresh fluid milk would become available, or more available to food aid recipients, less product would need to be dried and stored, thus eliminating the cost of drying for the processor, and reducing the cost of storage for the government. Also, product would not be going out of condition, because of long periods of storage, and end up being used in animal feed, at great loss of value.

There is much concern and interest in calcium in our diets these days. Medical people tell us the American diet does not contain enough calcium. Doctors and nutritionists tell us that women, in particular, need to increase their calcium intake. We believe if fresh fluid milk was readily available in food aid programs, it could greatly improve the diet of those recipients.

We realize that CCC does not purchase or own fresh fluid milk and probably should not. We are sure it would be possible to distribute fresh milk through the issuance of purchase certificates, or by some other reimbursement procedure, since USDA is already purchasing dairy products, and they are considered surplus commodities.

We would be interested to know if such a program could be initiated by USDA within the framework of present legislation. And if not, we would suggest that present provisions be amended to encourage the distribution of fresh milk through food aid programs.

Perhaps states or state and local agencies could purchase milk on a bid basis to avoid domestic market distribution—disruption.

In summary, then, and in conclusion, we would emphasize the need we feel to reverse the trend and again see more commodities, perhaps, and less cash being distributed. We would hope that fresh fluid milk would be made available to more of those people who qualify to receive aid through our food assistance programs.

Also, let me add, who really knows if the 5 billion pound figure that will trigger a cut in our current support price for dairy products is the right one. With the increasing need of our domestic feeding programs, is past history an accurate indicator of our future food aid needs? In all probability, we will see the reauthorization of the Older Americans Act, and the continuation of the temporary emergency food assistance program, and more, rather than less, food will be needed to assist our people that need it.

Mr. Chairman, this concludes my statement. Thank you for this opportunity.

Mr. GRANDY. Thank you, Mr. Schlitzer. And I would have to say that based on your testimony, I think you very much belong on this panel and providing some very enlightening information.

On that note, I will turn it over to my colleague.

Mr. TAUKE. Thank you, Mr. Chairman.

All of you had the opportunity to hear each other's testimony, so I would like to get a little reaction. First of all, Jean, you suggested in your testimony that you would like to be offered some additional products, and gave a rather substantial listing of preferred products. Sonia, what is the chance of that happening?

Ms. CROW. First of all, I would like to thank the other members of the panel for being supportive on the use of commodities. When I got up here, I did not realize that was going to be the case, so I thank my respective panel members for that show of support, and I think that is just an indication of the high quality of commodities that are available.

In terms of increased variety, I have taken some notes, here, because I think there are some important points that are being made. I would like to say, first of all, that USDA is already mindful, as is the rest of the country, about the need to reduce the fat content and sugar and salt, and we are starting to make those modifications in the commodities that we make available throughout our entire distribution of commodities, whether it is the school lunch program or NPE or the T-FAP, or whatever, we are becoming more and more mindful of that, working on the recipes and the contents of these products. So that is one thing that we are doing.

In terms of variety, that is certainly something that is important to us as we try to continue to make commodities attractive. We have added a lot of interesting commodities to the list. For example, I mentioned that as a bonus, we can now have frozen cherries, ground beef. We will not say that these will go on in perpetuity, but these are good, high quality products. We have salmon, pears, a lot of things that some people would consider a little bit esoteric, and a lot of glamorous commodities that are provided. We do not just give flour and milk and the standard stuff.

Mr. TAUKE. If I may interrupt there. How is it that one month you would have pears, and the next month you would not, or you would have frozen cherries, and then you do not. What determines that?

Ms. CROW. Because these commodities programs are directly linked in with our price support and surplus removal activities at USDA. So part of that is just a question of the marketplace. In terms of surplus removal, if it turns out that the almond growers in California need a little bit of help, then we are going to have some terrific almonds that are going to be available. [Laughter.]

Mr. GRANDY. That is on the record, Ms. Crow.

Ms. CROW. That is on the record. That was last year, Jean. That was last year on the almonds.

Part of the issue, in terms of distribution, quite honestly, is a logistical one. It is a question of how much of a product is available and what program it can fit into in terms of being offered generally. Sometimes you cannot do that because of the nature of the product and whether its shelf-life or perishable. But in terms of greater variety, that is something we are working on in terms of trying to make sure that more adult tastes are addressed. I think as we increase the use of commodities, or I should say get back to where we started a number of years ago, and we get more of these programs involved in there, then our constituents, in a sense, will stop being merely the school children, which are right now, one of the greatest users of our commodities, because we do that through the school lunch program, and we will start having some ability to try to target things more for adult tastes. But I have taken notes, and I am certainly going to go back and discuss with the people at USDA who administer the CCC program, because all of us are working together. As I said, Secretary Lyng started task force, and he was not kidding. He said, look, all of you work on commodities, and get your act together and make sure those people get what they want and need. And we work through our problems.

And so, I promise you—while I give you no guarantees, I promise you that the issue will, indeed, be considered at USDA. We are going to try to make commodities as attractive to you as possible, in addition to the fact that they are such a darn good program.

Mr. TAUKE. How would it happen that, say, the school lunch program in North Central Iowa would have access to a certain commodity, but that the congregate meal sites would not have that kind of access?

Ms. CROW. That is what is called the tough questions. I am hoping John, here, is going to be able to bail me out on that.

Ms. BEATTY. That is a part of it.

Ms. CROW. But I can tell you one thing, if—I do not know if John can answer that——

Mr. TAUKE. I can get——

Ms. CROW. One thing I can tell you is as we get more and more people in the NPE community networked into commodities in general, what we have been trying to do is to get some trades. So that if you get commodities, there may be school districts that have excess of what they need, or if you are in a particular need at a particular time for a commodity that is warehoused somewhere within the state system for school usage, you can do some trades and some swaps. And the more communication, the more networking that we get, the better off we are to try to level out those types of changes.

Now, I think John gets the microphone.

Mr. MERZ. Let me attempt to answer that question as far as the school receiving a commodity that a charitable or NPE site would not. It is that we offer the same products to the state office of the nutrition program for the elderly as we do to the school programs. It was a matter of whether or not they accept the commodity we offer. Sometimes when we offer something education will accept it for their schools, but NPE will not accept it for their organization.

Mr. TAUKE. Jean, it looks like you are anxious to say something.

Ms. BEATTY. Well, part of it is the requirement that the commodities have to come into the state in full carloads for NPE. And so, as fewer and fewer of the agencies were receiving commodity foods, there were fewer and fewer of us that had to share this carload requirement. And then it gets to the point, do you want a carload of a particular item, or none at all. And sometimes the answer is none at all, thank you very much.

Mr. TAUKE. Is there any coordination between the aging services and the schools. Let us say if the schools want a half a carload and you want a half a carload, can that work?

Ms. **Beatty**. It does sometimes work——

Mr. **Tauke**. But that is done at the state level?

Ms. **Beatty**. It is done at the state level. Of course, now—we used to be more directly involved with the department of public instruction in Iowa. Now we are more with the Department of Social Services commodity distribution network. And I think both of them do try to make that work.

Mr. **Tauke**. What about the purchase certificates that Marv mentioned for fresh fluid milk? Is that something that has been reviewed or looked at or investigated?

Ms. **Crow**. Congressman, if it has, I am not aware of it. The reason that we, of course, are using the nonfat dry milk is for many of the reasons that Mr. Schlitzer mentioned himself, and that has to do with just handling the storage capabilities. It is very difficult to do that—in fact, it is impossible, really, with the quantities with which we deal, to do that with fluid milk.

In terms of the use of vouchers as a supplement, I am not sure, having not reviewed the legislation and the processes and the program number one, whether if it is legally doable under our current system. Number two, I am not completely sure whether it would be viewed as particularly desirable adjunct to the program.

Obviously, USDA has enormous support for the dairy industry right now through its farm bill legislation. Much of the fluid—the surplus fluid milk is converted into cheese, which is then distributed as a product. So I am going to have to reserve final comment on that until we can look at it further.

Mr. **Tauke**. Yes.

Ms. **Beatty**. If it would not be possible to distribute that in 8-ounce containers in the shelf stable, is that not a possibility? I tried some of those products at national meetings, and they seem to be acceptable.

Ms. **Crow**. There is, obviously, a lot of research that people are doing in terms of prolonging shelf life of fluid milk, partially because of acceptability to the end user, using fluid milk, rather than having to mix up nonfat dry milk, especially if it gets somewhat granulated, or if it does not taste as good as we all know milk should taste.

But there is a very high cost associated with the type of processing to do the ultra—I think it is called ultra high milk?

Mr. **Merz**. Ultra high heat, I think it is called.

Ms. **Crow**. Ultra high heat milk to make sure that it is a healthy product, as well as a palatable one, and it increases the cost substantially. That is the reason we do not use it.

Mr. **Tauke**. I just have one more question. This morning we did not spend much time talking about the USDA's proposal to give a basic grant each year to the state agency on aging, rather than give per meal reimbursement for the commodities and cash that come to support these nutrition programs. As one who is out in the field, Jean, would you prefer to get a per meal reimbursement or would you prefer to get, let us say, next year, the same amount you got this year, plus a little increase, and then you figure out how to manage the program?

Ms. **Beatty**. Well, since Congress has bailed us out when we have exceeded the cap, that is—that has worked out badly for us, even if we have had to wait for the money. If I did not have a rapidly growing program, if we stabilized the meal program so that you could use last year's meal figures for determining the coming year's reimbursement, there would be no particular disadvantage. But it would be a disadvantage, you see, if the programs were growing. And I think that the area agency directors this morning indicated that in Iowa, at least, our programs have continued to grow substantially, in spite of the fact that there has not been a great increase in the Federal funding.

Mr. TAUKE. What have you done in the past when you have come up against the crunch, and did not know whether Congress was going to bail you out or not.

Ms. BEATTY. For me that has not been a problem, because it is only in the last 2 years that we have gotten cash. I was one of the diehards that stayed with commodity foods through thick and thin. And it is only the last 2 years that we have gotten into the cash situation. So I am not a good—I cannot answer that. I am not a good resource for you.

Mr. TAUKE. Thank you all.

Mr. GRANDY. I thank you. Sonia, I think when you testified before the subcommittee previously we talked a little bit about pushing commodities and the obvious imbalance between the cash versus commodity. Utilization. And seeing as how we are right now, in this Subcommittee, between phase I and phase II, as Mr. Tauke mentioned earlier, in other words we have had a subcommittee mark-up and we are going to a full committee mark-up, is there an incentive in the form of an amendment we might be able to create to encourage states to use commodities at a greater level and in return perhaps get more commodities?

For example, I think when we spoke before, you lowered your threshold from 50 to 20 percent in a year's time, and that has produced an increase for commodity usage. Is that correct?

Ms. CROW. That is correct.

Mr. GRANDY. And we talked about this before. I cannot remember exactly what you said, because I do not have your previous testimony in front of me, but is there any advantage to allowing that threshold to drop one more time for more bonus commodities as an incentive to states to use more commodities?

Ms. CROW. Well, let me reiterate some of the comments that we had made earlier when we were talking about that. The reason we reduced the threshold to 20 percent rather than to zero is that there is a certain point at which there is the need for people to be supporting the commodity program. Otherwise, what will happen is what is happening in a number of states. It will dwindle away. The infrastructure will not be there. And so 20 percent seemed a very low threshold in order to encourage people to get what is basically a terrific value. But people have to give something back, in a sense, in exchange for getting the terrific value of the use of bonus commodities. They have to have some support structure and some networking within the state, otherwise they are going to keep hitting up against the problems that Jean was alluding to, in terms of carload lots, and networking, and understanding and getting the kinds of products you want on a consistent basis.

You have to at least keep some infrastructure within a state and local system in order to make the use of commodities logistically and practically possible, as well as desireable, in terms of the cost benefit, not only to the end user, but to the farmer.

And so, we felt at USDA that getting down to zero would be, in a sense, undercutting our own initiative. And that people who use the commodities ought to have at least some consistent basis upon which they use them. We hope it will go up, and the reason that we lowered the threshold for the use of bonuses was just basically to try to encourage more and more people to use the commodities.

Mr. GRANDY. Jean, you are in the field. Would you think a reduced threshold one more time, say to 10 percent would be advantageous.

Ms. BEATTY. I would like to see you increase it. You see, the thing that happens, and I am not trying to speak for all my counterparts, there may be other people who would obviously feel differently about it—but in Iowa, what part of what happened, when you say you reduced the threshold, and you say you went from 28 to 20, was people like me who had been at 100 who dropped down to 66, and that was coincidentally a part of that same system. But what happened at that time, it did encourage some of the area agencies who had cashed out totally to say, okay, we will take a few in order to help the state reach the goal of the 20. If you went to 25, there might be a few, a little bit more encouragement there. So I would not like to see you drop it, personally.

Mr. GRANDY. So you feel that by raising the threshold, you might be able to get a broader use of commodities?

Ms. BEATTY. Well, I would not raise it a lot, because then you are going to—the people who do not really want to be bothered with the commodities, I think there are some, and I know that in Iowa I know of two areas where 1988 they are going to show a little bit more commitment to the commodities than they did in 1987. And it was because they were coaxed into the commodities at all in 1987—I think that you have got to wait a little bit for this momentum to grow for the support of the commodities. But I think if you dropped it very much, it just erodes that commitment. But I know that there are some areas in the state where they had cashed out totally, and with the 20 percent, they did come back in to a minor degree. And now, this coming year, they decided, oh, well, they do like some of the products. And would like to have a few more.

Mr. GRANDY. Do you have any ideas of how to provide incentives to states to, to utilize commodities at a greater level, to somehow offset the 96 percent, 4 percent cash commodity ratio?

Ms. BEATTY. Well, I think improving the system and—I think that the federal, the state and the local level, we have learned a lot. I think that in Iowa, and this is probably more a local thing than you would find nationally, I think that the distribution network in Iowa, now that we know we are going to get a quarterly delivery—at the time that we were involved with the Department of Public Instruction, we would receive deliveries when the schools did, and they would receive their first delivery maybe October, and their last delivery in March, and so we would have to plan accordingly. And I think now that we know that we are going to have a quarterly delivery, it helps us to do reasonable planning.

So, the commodity network is not a rational system in general. I mean, I—that is my basic philosophy, an it never has been. You cannot expect it to be. You have to be willing to work within the fact that there are so many decision points and so many factors. But once you commit yourself to recognizing the advantages and the benefits, it is a system where it is worth it to work with the frustration.

I figure if I can work with the airlines, and I can work with the U.S. Postal Service, I can work with the commodities system.

Mr. **Tauke**. Sonia figures if she can work with the Congress, she can work with anybody.

Mr. **Grandy**. Well, then let me go back to one more item. You suggested that the USDA lower their specifications for salt, sugar, and fat. Now, Sonia, did you—did I understand you to say that you are in the process of doing that?

Ms. **Crow**. There has been a lot of review about the nutritional content of what we have provided, and concern and interest in fat, sodium and sugar content, and that is something we are starting to address throughout the entire commodity system. I might also add that we have ongoing research that we fund, specifically targeted to the nutritional requirements of older Americans, so that we can be more sensitive to the quality and type of product that we provide to older Americans.

Mr. **Grandy**. Jean, I would like you to answer that question, too. What specifically might you be talking about? You mentioned salt content in canned vegetables.

Ms. **Beatty**. That is right. And specifically fruits in their own juices, we would like to see. In fact, I think that you might find that is an incentive to other nutrition directors to increase the amount of commodities they would be willing to take if some of those factors are taken into consideration.

But I think, too, the other part of that—that whole question about the variety—if we are offered apples, why cannot we have them in more than one variety? And I suppose some of that has to do with the processing contacts and such. But that will also increase the opportunity for people to use more of the food.

You know, Congress can increase the amount of the dollar, like from 52 cents per meal reimbursement to 56 cents. But if we are not offered the variety of foods, there is no way we can work all of those into the meal.

We have to be offered the variety. You cannot offer people applesauce every day, but you might be able to offer them applesauce on Monday, and maybe later in the week they will want apple juice, and apple pie filling or apple pie on Friday. So, you see, we cannot always work into a given meal the amount of commodity reimbursement that Congress allows, unless we have that variety to work with.

Mr. **Grandy**. I think I am hearing you say that perhaps the best way to provide these incentives through the USDA as nutritionally and with variety, rather than with percentages.

Ms. **Beatty**. I think that is a big part of it. I think that is an incentive.

Mr. **Grandy**. Marvin, did you have a comment?

Mr. **Schlitzer**. Yes, I would like to make a comment.

Mr. **Grandy**. Sure.

Mr. **Schlitzer**. In my opening statement I said that I felt that I was somewhat out of place on this panel. But I should have gone on to say that after more consideration I realized that the people I represent have a vital, if not the primary role to play here in our food programs. In preparing my testimony for today, I learned that USDA is in a very low inventory state right now, in the supply of nonfat dry milk, and I wondered if that was true. And if it is, it concerns me very much and it motivated me to ask the question, would now be a time to initiate a fresh milk procurement program, rather than filling the warehouses again with nonfat dry milk.

I believe that due to some international sales that were recently made that stocks are down considerably. I do not know how much.

Mr. **Grandy**. Do you have any information on that, Sonia, can you respond to that?

Ms. **Crow**. I am sure we have information, but it is just not at my fingertips. The Department has that and would be more than pleased to provide it for the record, if you like.

Mr. **Grandy**. I think we would like that, absolutely, because it seems to me the whole thrust of this panel is to basically implement what you are talking about. You came here to push commodities, and we are trying to find ways to do that. I just know as a member of the House Agriculture Committee, this is one state that makes a broad use of the emergency food assistance program, as well. And so I want to be on record as saying "the more commodities the better," as far as I am concerned.

Do you have any more questions, then?

Mr. **Tauke**. No more questions for the panel.

Mr. **Grandy**. All right. Thank you very much. This panel is excused, then. And we have been at this now for a little over 2 hours. Does anybody feel like taking a 5-minute break for a moment?

All right. This also is a covert use for me to use the gavel for the first time. We will recess for 5 minutes until I gavel to order, and everyone hasten to their seats. Boy, the power of a chairmanship is awesome, I must tell you. [Laughter.]

[Whereupon, a short recess was taken.]

Mr. **Grandy**. Our next panel is made up of folks that live in the area that participate in these programs and I am sure will provide some interesting comments for all of us. For this second half, I will make this comment. I do not know what Congressman Tauke's schedule is, but I have to return to Washington, and will probably have to leave right around 3:30 or so. So I would ask folks who will be testifying if they want to summarize their testimony or shorten it in any way, this Committee would look favorably on that.

But let me introduce our panelists now. We have Mr. Paul James, who is a resident of Algona. Mr. Joseph Bradley, also of Algona—are you still with the Algona Development Corp, Joe?

Mr. **James**. Yes.

Mr. **Grandy**. OK. We also have, from Algona, the president of the Algona Senior Club, Neva Stevens, and Mr. Elmer Vermeer from Sioux Center, Iowa, who is with the Department of Elder Affairs, and also with the American Association of Retired Persons, is that correct? And finally, the former mayor of Mason City, Carl Johannsen.

So, on that note, why don't we begin with Ms. Stevens.

STATEMENT OF NEVA STEVENS, A RESIDENT OF ALGONA, IA

Ms. **Stevens**. Thank you. I am not just sure what I am supposed to be saying up here, but I am going to echo many of the things that I have heard previously. Bring out the things that, as a senior citizen, myself, that I feel are very important.

Of course, our congregate meals is outstanding, and we must continue that. Along with that, our meals on wheels, which is such a good program for senior citizens or any that are in this particular need of meals delivered to their homes. A well-elderly clinic is a vital thing that must go on to keep us going in good health. Our homemaker organization, or public health nursing. All of these factors are what will keep us going in our homes, or whatever location we happen to be in. One of the factors—we do not have a lot of transportation here in Algona. We have a taxi service which provides transporation—I believe it is only 5 days a week, which certainly stops a lot of us from being able to ride a taxi or get transportation, for instance to church, or other places that we would like to go on Sundays and other holidays and so forth.

There is no public transportation out of Algona, in any way, if we need specialized medication or help. We cannot get to Mason City, Fort Dodge, whatever way you need to go. It has to be by private transportation. To me, this is a big obstacle for the elderly in this area.

There may be other areas that we need assistance, but many of our programs that are ongoing, I think are very well worthwhile, and I think they should be continued.

Thank you.

Mr. **Grandy**. Thank you, Ms. Stevens. Why don't we continue with our Algona representatives, and turn the microphone over to you, Mr. Bradley.

STATEMENT OF JOSEPH BRADLEY, A RESIDENT OF ALGONA, IA.

Mr. **Bradley**. Mr. Grandy, I welcome back home to the hub of your district. Mr. Tauke, I welcome you to Algona, known as the other capital city.

Mr. **Grandy**. Could you hold the mike a little closer to you, Joe?

Mr. **Bradley**. And to all of our out of town visitors, welcome. Enjoy yourselves. Come back often and bring money. [Laughter.]

I am sure you, too, can all see that I am entirely too young and immature to know very much about the problems of the aged. But I have an interest. And my interest, as of now, is my close involvement with Algona's development and Industrial Corporation. Now our goal, in that group, is to promote and develop business and jobs in Algona. Our philosophical aim in that endeavor is to do those things in economic development which we believe will provide the greatest good for the greatest number of people.

For that reason, we would want to know better people like Mary Kahler, people like Paul James. We would like to know more about their organization and how ours can work with and cooperate with them. And I am sure that our friendliness, our desire to cooperate, will be measured by your increasing knowledge of them. Because of any activity that would interest and engage people like Mary Kahler and Paul James has just plain got to be good, and we would want to become more and more a closer part of that.

Now, if I were a pious and devout person, I would remind you that your work with the aged has had a very high priority for over 2,000 years. I believe it made Moses' big ten list. I think it was number four. He said, "Thou Shalt Honor Thy Father and thy Mother." And I think you people are to be highly commended by the way you are keeping that commandment.

Thank you.

Mr. **Grandy**. Thank you, Joe. And finally, let us turn the microphone over to Mr. Paul James, also of Algona.

STATEMENT OF PAUL JAMES, A RESIDENT OF ALGONA, IA

Mr. **James**. Thank you, Mr. Grandy and Mr. Tauke.

The work of the area agencies on aging has been excellent. I was interested in the work of these area agencies on aging, because of so many of our older people are living alone, and many times the families are out of town, living some place away.

The senior center is very valuable social asset. I would rank it equal to, perhaps even exceeding, the nutrition program. And everybody has been in favor of the nutrition program, so I think that needs to continue.

Within our agency, I have been on the advisory board for the area agency on aging, and the caliber of people I have had—have gotten to work with and their concern for the population of this area and throughout the nation, for that matter, they have shown them great concern.

In our own area agency, I would say that they have done an excellent job of furnishing the information and referral services. If somebody in our community has a special need, we have a list that we can refer to to help that person receive the help that they need. Since I have been associated with the group, we have got the well elderly clinic established. Our congregate meal program will soon celebrate its end of three years of services. We were a little late getting started in Algona, due to lack of space to hold one. It is growing, it is vital, it is serving a great need in the sociability of many people. And there is room to grow. There are a lot of people out there that need the continuing of this program, if we can get it to work.

The amount of time that has been given has been—from volunteers, has been terrific, as has been mentioned here before. And I, for one would hope that this program can continue, within our agency, I know, and I am sure it is true of other agencies. They are constantly fine-tuning the program to see if they can make it work more effectively. And they try to make it as cost-effective as possible. I think those of us of the older generation are aware of the fiscal responsibility that we certainly need to exercise in this nation of ours if it is going to remain strong is that we do be as cost effective as possible, and serve the people that need service. The health care problems of the older generation, there is quite a segment of them, but it is in—they are in dire circumstances.

This health care cost has been terrific, and I do not know what a lot of people are going to do about it. But our agency, and I am sure most of the rest of them have done likewise, we have come up with programs. Support programs—whether they are supporting those that are giving health care to those that are homebound, they are just doing many things to help us to be able to serve those in our midst that have greater physical and emotional needs than many of the more healthy of us.

Mr. **Grandy**. Thank you, Mr. James. We will now ask Mr. Johannsen to make his remarks, and then we will complete the testimony with Elmer Vermeer.

STATEMENT OF KARL JOHANNSEN, A RESIDENT OF MASON CITY, IA

Mr. **Johannsen**. Congressmen Grandy and Tauke, it is a priviledge to be invited here today to testify. Being just an overworked taxpayer out here in the boondocks, I am naturally concerned about what you are going to do about the federal budget, the deficit. On the other hand, having been involved with the senior program since 1959, and also being on—having been on the board of the area agency for 6 or 8 years, I am also concerned about what you are going to do with this Older Americans Act.

During the years that I have been working with the senior citizens, I have seen a great many things happen that have been of benefit to the older generation. I am not going to take a lot of time by breaking them down and enumerating them for you, but I think there are places to make changes and make some cuts in the Federal expenditures to help balance that budget, other than from the agency which we are talking about this morning.

I thank you for the privilege of coming here, and expressing an opinion that I hope you can maintain the thing, at least as good as it is today.

Mr. **Grandy**. Thank you. Elmer.

STATEMENT OF ELMER VERMEER, DEPARTMENT OF ELDER AFFAIRS, SIOUX CENTER, IA

Mr. **Vermeer**. Thank you, Congressman. I, too, am happy to be here with you gentlemen this morning. I appreciate the opportunity to submit a testimony to you regarding the Older Americans Act. I would like to share with you some of my views and I will make this brief.

I have just recently been asked to serve as a commissioner to the Iowa Department of Elder Affairs, and therefore may not share all of the perspectives of others that serve on the Commission. However, I am not new to the programs and services for the elderly. In 1968, I began working for the City of Sioux Center as Director for elderly housing, transportation, and other services. I have also been actively involved with the operations of Iowa Lakes Area Agency on Aging since 1977. I have served as Chairman of the Board for that organization since 1979. In these capacities, I have learned much regarding the needs and problems of the elderly in the State, and particularly in Northwest Iowa.

Funds from the Older Americans Act help fund a variety of services in the State of Iowa. The services range from nutrition programs to information and referral services, home health services, employment opportunities and counseling. The basis for most services funded or provided under the act are designed to offer alternatives to people at risk of being placed in a nursing home or to encourage active involvement by the elderly in society.

Local flexibility and involvement by the elderly in the planning and operations of the programs and services under the Act has been an important factor in the making the programs successful. This local decisionmaking and involvement by the elderly helps target the limited resources available to best serve the local priority needs.

Perhaps the largest area of concern for older people involves the issues of health care. There are concerns about catastrophic health care, medicare supplemental insurance, early dismissal from hospitals, and community-based home health services. Many of these issues are not directly covered by the Older Americans Act, but all are issues of importance to the elderly.

Regarding home health care, the service has been changing rapidly in the rural areas. DRGs and the rapidly increasing elderly population have both been major factors in these changes. In less than two years, most of our rural counties have moved from having one small home health provider in any county to as many as four agencies attempting to serve the population in need.

Prior to these changes, the county public health agency was the traditional provider of home health services. Now the providers include public health, private for profit and hospital based providers. Most provide similar services; a few offer extra services like respite and hospice care. Some provide service 24 hours a day, 7 days a week, while others are primarily available only 5 days a week and with more traditional work hours. In some ways this competition has been good. In other ways, it has caused problems and confusion for funders and those needing the service. I believe that one area the Older Americans Act needs to address is the idea of Area Agencies on Aging, AAAs becoming involved with coordinated case management. Most area agencies are deeply involved with the provision of information on available services to the elderly and their families. They also help fund a number of those services. I feel that the next logical step is to fund AAAs to provide a system of coordinated care plans for individuals, as well as monitoring the provision of that care.

Case management is an idea which is also being discussed for the mentally ill, the developmentally disabled and the mentally retarded. But based on my understanding, there seems to be a major difference between case management for the elderly and the others. That difference is that the system for the elderly is an effort to help the elderly individual avoid being put in a care facility and other groups are setting up a system to substitute community-based care for existing institutional care clients. Both have similar goals; happier clients in a more pleasant, home-like, community setting, and presumably lower cost for most clients.

In the short term, a system of long-term care, case management, would be costly. However, in the long run, it would provide the foundation for a system to help delay the need for nursing home care, delay the need for dramatic increases in the number of nursing home beds and facilities, and provide a more desirable setting in the minds of the rapidly growing population in need of long-term health services. The system calls for building upon family and community support systems for the care plan, and not replacing them.

I believe that state and area agencies on aging working together have been doing an excellent job, considering the funds available, the enormity of the task, and the many demands placed upon them. I believe they serve an important function in targeting resources, informing and helping direct seniors to available services, and that they should have expanded responsibilities as case managers for the elderly.

Thank you very much.

[The prepared statement of Elmer VerMeer follows:]

PREPARED STATEMENT OF ELMER VERMEER, DEPARTMENT OF ELDER AFFAIRS, SIOUX CENTER, IA

Congressman Grandy and Congressman Tauke:

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Thank you.

Respectfully submitted,

Elmer H. VerMeer

Mr. **Grandy**. Thank you, Elmer. Mr. Tauke.

Mr. **Tauke**. Thank you, Mr. Grandy. I was somewhat surprised to hear that there is no method of transportation out of Algona. If you need to receive services from outside of Algona, let us say health care services, how do you get to wherever you have to go? From Algona?

Ms. **Stevens**. By private transportation. By car or a friend.

Mr. **Tauke**. The area agency on aging does not provide any transportation service outside of Algona.

Ms. **Stevens**. I do not know of any.

Mr. **Tauke**. Do any of you know?

Is that a significant problem, do you think for people in the community?

Ms. **Stevens**. Oh, yes.

Mr. **James**. I do not know how big a problem it is, not having worked closely with it. The Department of Social Services, or those who need to go out of town, there is some transportation provided there, but most of the rest of the people that do not drive have to depend on friends, I think, who drive, if they have to go out of town for a doctor or other, for services that require from—into another community.

Ms. **Stevens**. I just recently had an experience of my own. I had to see an ophthalmologist. Algona does not have an ophthalmologist. I went to Mason City, and realizing that my eyes would be dilated, I had friends that had enough foresight to tell me that I could not drive my car and expect to get back to take me, and so, of course, they volunteered to take me. But otherwise, how do we do those things unless it is through volunteers or private friends, or whoever we can get to take us from one place to another.

Mr. **Johannsen**. So long as you brought up the item of transportation.

Mr. **Tauke**. Yes.

Mr. **Johannsen**. Over the years that I have been working with senior citizens, every year they put up a list of priorities that we have got to take up under consideration. Every year transportation is the first or second one on the item. Every year. And it has been the same way for the last 15 or 20 years and we still do not have transportation.

Mr. **Tauke**. I was just going to ask you if that was not a priority. Now, you are Mason City, right?

Mr. **Johannsen**. Right.

Mr. **Tauke**. Do you have any kind of transportation services provided in Mason City?

Mr. **Johannsen**. What do you mean?

Mr. **Tauke**. Well, within Mason City or outside Mason City for Senior Citizens?

Mr. **Johannsen**. Well, there is a bus line within Mason City, and we also have the Greyhound Bus Line which runs in and out of Mason City.

Mr. **Tauke**. But you do not have any kind of vans for senior citizens.

Mr. **Johannsen**. We do not.

Mr. **Tauke**. We have it pretty good over in my district, I guess.

Mr. **Johannsen**. I had a visit over to Austin, Minnesota, a couple of months ago, looking over the senior center. And they have a bus. Austin has no bus service in the town, but the senior citizens have a bus. I talked to the director, how did you get a bus? Where did you get it? I went to the Department of transportation of the State of Minnesota and they gave it to me. So they got the bus, and they have got a lady that runs it. She has got a dispatcher's office, and radio contact with the bus drivers, and they pick up the seniors and haul them all over the country. I think it is wonderful, if you can get the bus. Now, if you can figure a way to get the bus, we would be glad to have it.

It has been a problem for years. It has been difficult. A lot of money has been squandered on transportation programs, of various kinds. They do not seem to pan out.

Mr. **Tauke**. The congregate meal sites is another obviously popular program, and one which several of you expressed support for. In your mind, do you think that the congregate meal sites that we have are meeting the need? Or maybe looking at it another way, do you know senior citizens who would like to go to a congregate meal site, but cannot get there. Are not going.

Mr. **Johannsen**. I think you see that—in our town, I know it happens. I suppose in bigger places you see more of it. But a goodly number of the people who should be attending the meal site do not because they cannot get there.

Mr. **Tauke**. You anticipated my question, there. I was going to say in Algona, how do you get to the congregate meal site.

Mr. **Bradley**. The City of Algona subsidizes a taxi.

Mr. **Grandy**. Paul, would you give Joe the microphone so that he can be heard?

Mr. **Bradley**. The City of Algona subsidizes a taxi service. It is not completely free, but it is a very bare minimum of operational costs. They do not provide charge for anything except an amount to cover gas and oil. It is very small amount for depreciation. But the senior citizens, to my knowledge, use that a great deal. Also, there have been a couple of fellows who have retired and have gotten themselves a good automobile, and have held out willingness to drive patients to Mason City, to Rochester, and to Iowa City, and they are kept real busy. There probably will be more do that very thing. It is sort of like a limousine service. It takes you to Iowa City in a very nice automobile. It is better than the taxi that Algona has.

Mr. **Tauke**. Yes, Mr. James.

Mr. **James**. I might say that for the local transportation, the senior citizens can ride for 50 cents. The budget over a year's time, the fees that the city collects from operating the taxi affords about a third of the expenses, the city contributes about a third, and the area agency department—I do not remember just what it is, the North Iowa Council of Governments or some such thing as that—I think that is the name of it, so they contribute a third. So that is our local transportation set up within the City

Mr. **Tauke**. The proposal has been made, and was talked about earlier today, that for some of the services that are offered in the Older Americans Act that we have some kind of charge or fee. How do you react to that kind of proposal?

Mr. **Vermeer**. I react favorably. I think a fee ought to be charged.

Mr. **Tauke**. Do you have any concerns that if we charge a fee that some people will drop out, let us say not come to the congregate meal site or not use whatever transportation service might be available?

Mr. **Vermeer**. Oh, I am sure that is true. And I was not thinking of the congregate meals. I do like the suggested prices we have. Although I think there ought to be more emphasis put on that people ought to give according to their conscience.

Mr. **Tauke**. Do any others have any reaction to the fee?

Mr. **James**. Within our nutrition council, this has been discussed many times. If there should be a graduated recommendation, or whatever. And it is a very sensitive subject, and it has been the consensus of opinion that the people that need the service most would be the ones that would drop out. And it is surprising what, if you drop a few participants in the meal program, how much per plate the cost of the food service goes up. So it is a very delicate matter that has got to be handled very carefully. I think it is necessary that we encourage people to contribute according to their ability. But at the same time when you say this is a minimum, I think it would have an adverse effect on the meals program.

Mr. **Tauke**. My last question is this. If you were going to say to Fred Grandy and Tom Tauke, there is one thing we want you to do, what would that one thing be?

Ms. **Stevens**. One of the things we do not have very good facilities for a senior citizen, and that is my priority right now, that we have good facilities. We are in an old library building, the walls are crumbling, and even with remodeling, we still will have crumbling walls. And it is set back from the street quite a ways. We have people that have walking disabilities. To get there we have to park way out on the street. To carry anything—we have pot luck meals twice a month, and we have to carry this material into the building. It is very difficult to do so for some people. And of course these are my priorities, better facilities, so we could have our own cook to cook our own congregate meals. They tell us it is cheaper to do so, and I hope that that will be achieved in my lifetime.

Mr. **Tauke**. Now, who runs the senior center here? Is that a city-owned facility, or is it run by the area agency on aging?

Ms. **Stevens**. The building is owned by the city.

Mr. **Tauke**. OK.

Ms. **Stevens**. And they allow us to use that building. But we are spending a lot of money in the upkeep of that building. You realize that an old building has to have a lot done. In fact, we are spending $1,000 right now to paint the walls and to make it presentable. But this is not because we want to continue being there as we are, but it is a stopgap. We want it to be good facilities for ourselves.

Mr. **Tauke**. Where do you get the $1,000.

Ms. **Steven**. Donations. We have dues for membership in our club. We have 80 members, but we only charge $2 a person, so that does not make much. We do have fundraisers, and we are very willing to do that type of thing. We are not necessarily asking for a complete handout. We do work, we would like to have some assistance, however.

Mr. **Tauke**. Do any of the rest of you have any priorities for us?

Mr. **Vermeer**. Yeah, I have it—catastrophic illness. That—I know that is going to be an item that you are going to be working on.

Mr. **Tauke**. Right.

Mr. **Vermeer**. And I have seen some of the plans and it is a beginning. I think it is happening. We are going in the right direction.

Mr. **Johannsen**. You know, you are talking about senior centers. I have visited a lot of senior centers, and there is one thing that I have come to a conclusion of. Too many senior centers turned out to be an old folks home. That is why many people will not go down there. They do not want to associate with them old people. What we need as a senior center is a senior activity center, not an old senior center where you sit in the rocking chair or play cards or read a magazine all the time. We need centers where we have some activity for the seniors. Seniors are not supposed to go back and sit down and die, you know? They are supposed to get up and do something.

So senior centers should be an activity center, and not just an old activity center. But how do you get that done? That all costs money, you know?

Mr. **Tauke**. Well, thank you very much.

Mr. **Grandy**. Thank you, Tom. I want to pick up a little bit on what your wish list might be here, but also talking about how we transfer funds around the program. There are basically three areas after you factor out the nutrition services. I think I am correct in assuming, that nutrition services amount to about 65 percent of the monies that go to the agencies. And then after that you have monies for in-home and legal services. I want to ask you folks, because there has been some talk in committee, as Mr. Tauke brought up, about legal services. Is there a need for legal services in this area, either in Mason City or Algona?

Mr. **Bradley**. You mean providing legal talent to aged who need it and cannot afford it?

Mr. **Grandy**. Basically, that is what I mean, yes.

Mr. **Bradley**. I think if it is a problem, it is on the bottom of the list.

Mr. **Grandy**. So you do not see the need for any kind of legal set-aside?

Mr. **Bradley**. You can believe——

Mr. **Grandy**. In the dispersement of those funds here?

Mr. **Bradley**. You can believe this or not, Congressman, there are a lot of good attorneys in Algona that will take care of a situation, and if it needs to be done for nothing, it will be done for nothing. I do not think we need to complicate life in Algona by involving ourselves in legal services. I cannot think of a single person in Algona—I do not know of any—who have had a legal problem and it could not be taken care of because it is too high priced to get a lawyer.

Mr. **Grandy**. Karl, would you like to comment?

Mr. **Johannsen**. I think if that was eliminated, as far as Mason is concerned, we would never miss it.

Mr. **Grandy**. Then let me ask you to address this, Elmer, and I realize you are new in the commission, but are we perhaps seeing a reduced need for legal services, and perhaps an increase to transportation needs, or perhaps a need to replace decaying facilities?

Mr. **Vermeer**. As far as legal services, I know in my area, northwest Iowa, there is no need for legal services. I have talked to numbers of attorneys who have said, bring us your people who are not able to pay, or who can pay a percentage, and we will be happy to take care of them. Because they work with families and estates, and so they are glad to get that kind of service.

Mr. **Grandy**. So really in our communities we are talking about a service that is made voluntarily just through the goodwill of the attorneys in the area.

Mr. **Bradley**. I would say that is true.

Mr. **Grandy**. Paul, go ahead.

Mr. **James**. If there was a need of anybody in our community to receive legal services, the way our agency would handle it currently is we would call the agency office in Mason City, which is the headquarters for our agency, and they would review the problem and they would be referred to an attorney to take care of it. That has worked satisfactorily, and I believe that is the consensus of the agency—the board of directors, or the director of the agency, that that plan has been working satisfactorily and we have no need to expand the service.

Mr. **Grandy**. Let me turn now to something that is really a topic that we have not discussed during these hearings, but probably should raise. Our Chairman, Mr. Kildee, of Michigan, will have a subsection D to Title III, which is a $25 million authorization for in-home services. Now, Carol, correct me if I am wrong, but are there provisions in there—or Susan, you probably know—for some kind of Alzheimer's disease research?

Staff. Alzheimer's would be one of the elements of the issue.

Mr. **Grandy**. Let me ask you about this. Are you seeing an increased prevalence of Alzheimer's disease in these rural communities? And, of course, I include Mason City. So do you see a need for this kind of increased funding and focusing specifically on that group in terms of respite——

Ms. **Stevens**. Evidently, there is quite a great need for that because our local chair facilities are proposing a special wing for that particular care.

Mr. **Grandy**. Mr. Kildee's proposal, I believe, would address this need in the home, though, through a variety of services. Respite care, basically being a chance to provide a little bit of respite for people who are caring for Alzheimer victims. I am trying to get, I guess, through your combined testimony your feeling for the need out here in Algona.

Elmer, would you comment?

Mr. **Vermeer**. I do not think there is a greater need than health services. I believe that I could speak for all the elderly, and that is the greatest fear they have is becoming ill. Insurance costs are terribly high, as we all know, and there are people who are not able to buy the supplemental insurance.

For the Alzheimers, that has got to be a real issue, and I really believe that there has to be a certain care directed to those people, and preferably in-home care if that can be done, because that is cheaper, for one thing, and people enjoy being in their homes.

Mr. **Grandy**. Were you going to say something, Paul?

Mr. **James**. Yes, I was. I was going to echo the same sentiment that was just expressed. There is a considerable number of Alzheimer patients in this community. For the most part, they prefer to be cared for at home. And it falls upon family members to supply a great deal of that care. But they also need some training to be better care givers, and they also need some relief so that they can get away from the situation for a time to rejuvenate their own self worth, I guess, for lack of a better word for it. They need some time away from the constant grind of the care. It is quite a critical deal. And wherever it can be handled in the home, it is far more economical to do it that way.

Mr. **Grandy**. Is that pretty much the consensus of all of you, that if we can, we want to address Alzheimer's disease through home care, as opposed to institutional care.

Mr. **Bradley**. I have a question here. I am only conscious of having heard of Alzheimer's for about 2 years. What did we call it before then? It has gotten to be very popular?

Mr. **Johannsen**. They used to call it senility. You were getting senile. That is all they would tell you about it then.

Mr. **Bradley**. Well, is that a disease or a condition of age?

Mr. **Johannsen**. Well, it is something now that a great deal of research is being going on, taking place, to find out what is going on——

Mr. **Grandy**. We have some medical personnel who are in the next panel, and with your permission I will ask that question to them so that we can find out.

Mr. **Bradley**. I think the popularity is second only to AIDS.

Mr. **Grandy**. I am not sure I would use popularity.

Mr. **Johannsen**. Frequency in the newspapers. But I know in Mason City an organized Alzheimer's society, and they get together and they work out some of these problems they are having. They are taking turns relieving, we will take care of yours. Releasing—you take a couple of days off, bring them over to my house. And I think the program of long-term care is a bigger concern to the elderly, generally, than the Alzheimer's disease is.

Mr. **Bradley**. Where did we come up with that name?

Mr. **Tauke**. I think it relates to the scientist who discovered it.

Mr. **Johannsen**. They named it after Dr. Alzheimer, I think.

Mr. **Grandy**. Well, that basically concludes what I wanted to ask you folks. I want to thank you for being on the panel. It is very helpful to have your opinions in terms of putting together testimony for this reauthorization.

Mr. Tauke, do you have anything else?

Mr. **Tauke**. No. Thank you very much.

Mr. **Grandy**. Our final panel consists of three individuals. We have Rosemary McKay, who is a registered nurse and Director of the Professional Nursing Service in Spencer, Iowa. We have Sherry Thu, Director of the Spencer Municipal Hospital Community Health Services in Clay County, and Ruth Lindstedt, Director of the Amicare Home Health Services of North Iowa, Inc., in Mason City.

I have just been handed a note that I have only about a half hour to remain here. Let me just say before I forget that we have some testimony from some individuals who were not able to participate today. Mr. Dick Ambrosius has sent us some testimony on the whole subject of cost sharing and means testing. He is with Phoenix Systems in Sioux Falls and has been Executive Director of an area agency on aging in this area and has participated in the Iowa Area Aging Agency. And we also have some more testimony from Swiss Valley Farms.

I will also say that the hearing record will remain opened for two additional weeks for any further submission. So we can have extra testimony for those people who could not participipte today.

In the interest of time I am going to ask you ladies, if you will, to summarize your testimony so we can, perhaps, address some of the questions that have come up in terms of home health care.

Ms. Lindstedt, would you like to start?

STATEMENT OF RUTH LINDSTEDT, DIRECTOR, AMICARE HOME HEALTH SERVICES, NORTH IOWA, INC., MASON CITY, IA

Ms. **Lindstedt**. I do want to thank you, Congressmen Grandy and Tauke, for the opportunity to speak today and to testify. I do have a written statement which I have submitted for the record and I will not read that.

Mr. **Grandy**. Your statement will be included in its entirety, though, in the record.

Ms. **Lindstedt**. There were a couple of things that I would like to say to sort of give some life to some rather dry comment in the written record. And that is one area in an issue that faces the elderly is what is happening with the Medicare reimbursement for in-home health services.

Basically, the Medicare program, though it has been restrictive in terms of hospital care, is also being restrictive in terms of services for the elderly in-home.

That makes the interest of the Committee, as they look as the Older Americans Act, in in-home health care, very important to an individual like myself. The problem that I see is that the Medicare provisions do not allow for any kind of services for individuals who have chronic long-term conditions. It is definitely designed for treatment of acute conditions requiring skilled services. That has been interpret increasingly restrictively, and, because of that, is a real issue for the elderly population.

The concern about long-term term for the elderly is definitely there. I would be concerned as one talks about that about cost and how much support can be provided in the home setting with some understanding of what it does cost to provide in-home services. However, especially if they are provided by agencies or services, I think we need to understand that, on the other hand, services provided to the elderly by volunteer or non-supervised personnel could be a real issue. And I would like to address that further, perhaps at some other time.

The other area that has been addressed earlier by several people is the community-based services, in-home and community-based services kinds of programs, some sort of coordinator-case-managed system, and that makes a lot of sense to me. I think there are a lot of things that can be done to direct elderly into programs and services that are available, and that could be done in a cost-effective kind of way.

[The prepared statement of Ruth A. Lindstedt follows:]

TESTIMONY REGARDING IN-HOME HEALTH CARE
FOR A HEARING ON
REAUTHORIZATION OF THE OLDER AMERICANS ACT

prepared by

Ruth A. Lindstedt, Agency Administrator

AMICARE HOME HEALTH SERVICES/NORTHERN IOWA, INC.
Mason City, Iowa

April 24, 1987

PROBLEMS AND ISSUES FACING IN-HOME CARE SERVICES

Medicare Coverage for Home Care. The U. S. General Accounting Office (GAO) released a report in January, 1987, which underscored some of the problems encountered by the elderly population of our country in obtaining in-home health care services. According to the GAO, the Medicare eligible population is not receiving the home care benefits to which they are entitled because the Department of Health and Human Services and its contractors, intermediary insurance companies, are being too stringent in applying the rules. The increase in denials of reimbursement to home health care agencies offering services to the Medicare eligible elderly has increased by an unprecedented 65% in the past year. Far too many denials are based on the interpretation by an intermediary that an individual is not "homebound." The increasingly strict interpretation of "homebound" almost limits the Medicare home health benefit to those who are nearly immobile.

In addition to the more restrictive interpretations that are being made of what does constitute covered home care service to the Medicare eligible population, the DRG-based reimbursement system for hospitals does lead to a higher number of individuals who demonstrate need for home care when they leave the hospital. The GAO report states that 37% more individuals actually require home care now than in the pre-DRG years. So, in effect, the elderly can expect to leave hospitals sicker and, when they do meet the restrictive guidelines for home care, should expect to receive only highly skilled services for a limited time. The elderly person's need for help in performing required daily functions such as eating, dressing, getting in and out of bed, and so forth, are not given much consideration in current Medicare home care provisions.

Lack of Long Term Home Care Programs for the Chronically Ill Elderly. The GAO report cited above also notes that in 1982 3.2 million elderly needed help to perform needed daily functions. 1.9 million of these said they had support to carry out these functions--71% said the help was provided by relatives, 21% that it was provided by a combination of paid and unpaid help and 8% that they relied totally on paid assistance. The difficulty here is that the number of elderly--especially the number of elderly 75 years old and older--is increasing at a faster rate than any other segment of the population. And, it is this age group that is subject to the highest number of chronic conditions leading to a decrease in functional capacities. However, there is no national policy or plan which addresses this issue of the need for long-term in-home care which could protect the health and well-being of our elderly. Rather, our nation seems bent on consigning our aged population to nursing homes or to leaving them in their homes bereft of the care they require.

Lack of Clear Standards for In-Home Care Providers. Although the State of Iowa has an exemplary program which supports in-home care for the elderly--the Homemaker-Home Health Aide program--it by no means reaches all those who require assistance to meet the extent of their home care needs. It is at this point that one would like to see the State specify a requirement for the training and supervision of in-home personal care providers. Untrained and unsupervised providers soliciting the elderly to provide home care can be a tremendous threat to the well-being of that age group.

Lack of Coordinated Community-Based Services to Assist the Elderly to Elect In-Home Care Options. Though some states sought and obtained Medicaid waivered status to design and fund home and community-based service programs to offer the elderly an opportunity to remain in their own homes rather than be forced into a nursing home placement, Iowa was not among them. However, it would appear that more should be done to further work in this direction.

CONSIDERATIONS AND RECOMMENDATIONS

*** Congress should demand a reconsideration of the way in which the provisions of the Medicare home care benefit are being interpreted and applied.

*** The restriction of the Medicare benefit to only those who require highly skilled levels of care with the exclusion of those who are chronically ill and whose health may suffer because of significant functional limitations should be re-examined. Some form of long-term care coverage for our chronically ill aged is required.

*** Provision should be made for a model law to be developed which would assist states to establish and enforce minimum standards for home care programs not participating in Medicare certification. This would include standards for the training and supervision of personal care providers.

*** There should be additional opportunities made available for states to develop and set in place programs that are effective in offering the elderly the option of home care in the community setting as an alternative to nursing home placement. These "opportunities" should be in the form of funding to develop cost-conscious programs that will build on the experiences of the Medicaid waivered programs.

SUMMARY

Though the Older Americans Act has provided the incentive in many instances which is necessary to promote programs and activities that benefit our nation's elderly population, there are still wide gaps in some program areas through which our elderly fall. One of the gaps is in the availability of affordable, quality in-home care services for the chronically ill elderly with significant limitations to meet their requirements for daily living activities. Because of the aging of the population as a whole, this area of concern cannot be ignored. If through some changes to the Older Americans Act the issues highlighted here can be addressed, the health and well-being of our elderly can surely be enhanced.

Mr. **Grandy**. Thank you, Ms. Lindstedt. Ms. McKay.

STATEMENT OF ROSEMARY MCKAY, R.N., DIRECTOR, PROFESSIONAL NURSING SERVICE, SPENCER, IA

Ms. **McKay**. Thank you both for the opportunity to be here. I really have no prepared statement, so I will be very brief.

I represent the private sector in home health care agencies. We have been the recipient of some of the Older American Act's monies, funds. I see very much of a need for increased funds for in-home health care. I was glad to hear that maybe that is being considered with additional funds.

It is very important for the elderly to remain independent and in their own home. To do that, many of them do need some in-home health care services. The elderly are very unknowledgeable, as was said, about Medicare. So, often, they will go into the hospital or have a problem and they will just think, that's OK, Medicare will take care of it. When, in fact, Medicare is paying for less and less of their health care costs.

In turn, it is maybe monies such as from this bill here that may be able to provide for some more in-home health care for the elderly that do not meet the Medicare guide lines. Those that kind of fall through the cracks.

Cost effectiveness, you know, is a concern, is a problem. We can't ask the government to take care of everyone or be everything to everyone. I think, as you get more agencies involved in giving home health care, you are seeing better price competition, cost effectiveness coming about. Which is a good goal to realize.

The other issue, too, is catastrophic illness. I do think that is a very major concern and should be for everyone, especially for the elderly.

And that is all I would like to say. Thank you.

Mr. **Grandy**. Thanks, Ms. McKay.

Ms. Thu, why don't you make some remarks and then we will have some questions.

STATEMENT OF SHERRY THU, DIRECTOR, SPENCER MUNICIPAL HOSPITAL COMMUNITY HEALTH SERVICES, CLAY COUNTY, IA

Ms. **Thu**. Thank you, Mr. Grandy. I have to tell Mr. Tauke, too, that I'm not really into politicians, and, as I was coming to this, I was telling people that Mr. Tonke was going to be here, and they did crack up, because it is "Tauke." [Laughter.]

I wasn't pronouncing your name correctly, either.

At any rate, I wasn't really sure what this was all about. I have learned a lot today and I do want to just mention that the monies that we receive from the Older Americans Act, at least now I know where they are coming from, but they are a very very small part of our entire budget. We do operate with public health monies, with Medicare monies, and have about a $300,000 budget. Greg gave me permission to say that.

So, at any rate, I do believe that we are crossing some very critical roads in health care, and, again, I would like to agree with this person who talked first here, that the DRG system has had some serious implications for care in the home. And, again, I think we are seeing a more critical patient in the home, we are seeing more of them, and we are seeing the more acutely ill in the home. When Medicare changed the prospective system for the hospitals they did nothing to change the reimbursement for home health care. Those criteria you still have to meet. They are very strict, they are getting stricter. A patient has to be home-bound, they have to be confined to their home. You can only provide intermittent care and that is interpreted very literally by our fiscal intermediaries. And the physician has to assign a plan of treatment, addressing the reasonable medical necessity of care. And, also, in order to have an aide in the home, a nurses aide, you have to have a skilled service in the home. And by that, they mean a physical therapist, occupational therapist, speech therapist or nursing, and those services can only be intermittent, before you can even get an aide in the home to provide the personal care that so many of these elderly do need.

I also want to mention that in our area we do have a lot of very concerned people for this very reason. They are not getting a lot of the health care that they need. They perceive—and I work out of the hospital, we are a hospital-based agency—they do perceive that they are going home sooner than they are ready, that they can't get into the hospital, and they look upon us as being not in a favorable light to them.

Also, the physicians are being regulated by their own professional review organizations. This is shedding another light on it.

At any rate, I do feel that we do need more of these monies, and, again, I've been very pleased today to hear that this Older Americans Act will be provided us with more monies. I have some figures in my testimony that I have submitted, talking about the population and how it is increasing. And I thought that it is interesting, the shifts in the demographics. We are seeing the rise of the old, the end of youth and the aging of the baby-boom, and I am one of those who is right in the baby-boom, and I guess I am aging too. I hope somebody is there to take care of me when I get into the sixtieth year.

One thing I do want to mention is that we do have a reason to be thankful for the improvement in medicine, lifestyle, and public health that has generated an enhanced standard of living as well as dramatic elevations in life expectancy that have occurred during the past century. However, we are still a far cry from successfully promoting and maintaining good health throughout the lifespan.

As a nurse, and I cheered at the back at one gentleman who said that we don't want these senior centers to become places where they just go and rock. We want to do something there that we can promote health and educate them and help them to learn to take care of themselves so that we don't get to the point that they are sick, because they will be living longer. We really need to stress health promotion and disease prevention. Again, 80 percent of the degenerative diseases that older people suffer could be prevented or postponed. And those are things like heart disease, hypertension, strokes, arthritis, that type of thing. And when I heard the people on nutrition talk about the salt content of food, and fat content, this goes right along with what we nurses are trying to promote, is wellness in the elderly. And we don't want them—I don't want them to get to the point where they are so sick and we have to care for them as sick. We need to prevent disease if we can.

Again, about 80 percent of the elderly remain in the home right now. Some of these elderly have the very basic needs and we need to address those needs with monies. We have homemaker-home health aide monies from the state of Iowa, monies from the Area Agency on Aging through the Older Americans Act. And these are the monies that help us to provide services to these individuals in the home that are not covered by Medicare/Medicaid and other third-party reimbursement.

So, thank you for those monies. I have some other figures in there about numbers of elderly that were prevented from being institutionalized based on the fiscal year 1986 report from the state of Iowa, from the homemaker-home health aide department. I also have a figure in there about what it costs for a 10-month period per client to provide the minimal service for clients in their home to prevent institutionalization. Just giving them that support.

I also would just like to add that because patient safety is our number one concern, that oftentimes we do find a need to have, to suggest to the patient or to the patient that institutionalization is oftentimes appropriate, because it is too expensive to provide a one-on-one type of care for that individual in the home. We need to get him into a larger institution where more than "a" nurse can take care of a larger number of patients.

Also, we are seeing a shift in family dynamics. Oftentimes, family members are out working. In a family, more of the American society is back at work. We are seeing that right here. And maybe they live long distances away so that they can no longer care for this elderly person.

In closing, I would like to say that the nation could benefit greatly from increased numbers of healthy long-lived citizens. It could suffer a loss of profound magnitude if its older population is ill, functionally dependent and socially impotent. Whether the trend toward an older America will ultimately be a boon or a drain on the nation is to a large extent dependent on whether or not we will be able to create an effective health-care strategy that not only keeps people well but is able to do so inexpensively. Thank you.

[The prepared statement of Sherry Thu follows:]

PREPARED STATEMENT OF SHERRY THU, DIRECTOR, SPENCER MUNICIPAL HOSPITAL COMMUNITY HEALTH SERVICES

TRENDS IN HEALTH CARE RELATING TO THE ELDERLY

I believe we're meeting some very critical crossroads in health care. Most of us are aware of the medicare prospective payment system - DRG's. In October, 1987, Medicaid will be implementing this system. There have been changes in incentives for hospitals. In order to contain costs, hospitals need to deliver less care in order to meet the financial award. People are apprehensive and concerned. They perceive being discharged before ready to go home and not being able to be admitted to the hospital. The Professional Review Organization is regulating the medical profession by providing second opinions on whether patients should be admitted to the hospital.

The trend to control hospital health care costs has some serious implications for health care in the home. There has been a ripple effect. We're seeing a more acutely ill patient in the home. By the year 2000, it is projected 100% increase of home care patients and they'll be four times as sick. None of the criteria for the medicare home health benefit has changed - i.e. homebound status, medically reasonable and necessary care, skilled services needed. If a patient in the home is not elegible for third party reimbursement, other Federal, State, and local dollars are needed greatly and being utilized. The system is very complex indeed.

"The dramatic demographic changes our nation is currently undergoing represent the culmination of three simultaneous age-related cultural shifts: the rise of the old, the end of youth, and the aging of the baby boom. Americans are growing older and living longer as well. Seniors will soon be the majority as the baby boom ages."[1] In 1980, the elderly constituted 11.3% of the nation's population. In the past 100 years, the total population has multiplied five times, while the over-65 population has multiplied an incredible fifteen times.

"We have reason to be thankful for the improvement in medicine, lifestyle, and public health that have generated an enhanced standard of living as well as the dramatic elevations in life expectancy that have occurred during the past century. However, we are still a far cry from successfully promoting and maintaining good health throughout the life span."[2] As much as 80% of the degenerative disease that older people suffer could be prevented or postponed. 89% of all non-dependent patients have at least one chronic disease. The elderly need to be motivated to become more educated through health promotion and disease prevention activities.

Long-term care and family therapy will be in demand by the aging population. 80% of the elderly remain in the home. Many of the elderly have some very basic needs and need supportive services to prevent institutionalization, i.e. personal care, help with housekeeping, Lifeline, visiting friends, M.O.W., Home companion service. At present this care is being provided at a minimal level. We will need more dollars to provide care to meed the demand for service. It is predicted that by the year 2000, 50% of all health care expenses will be related to the care and treatment of our over-65 population. I also would like to mention in the State of Iowa for FY 86, utilizing Homemaker/Home Health Aide monies, 7,399 elderly were prevented from being institutionalized. Recently, Sioux County did a study and it cost $635/ for a ten month period/client providing supportive services in the home. This figure is significantly less than the cost for institutionalization. I would like to state that because patient safety is our number one concern, insitutionalization is often necessary as many elderly live by themselves and aren't able to afford home companions.

"The nation could benefit greatly from increased numbers of healthy, long-lived citizens; it could suffer a loss of profound magnitude if it's growing older population is ill, functionally dependent, and socially impotent. Whether the trend toward an older America will ultimately be a boon or a drain on the nation is to a large extent dependent on whether or not we will be able to create an effective health care strategy that not only keeps people well, but is able to do so inexpensively." [3]

From what resources will reimbursement come?

[1] Dychtwald, "The Senior Boom", Hospital Forum, May/June 85

[2] Dychtwald, "The Senior Boom", Hospital Forum, May/June 85

[3] Dychtwald, "The Senior Boom", Hospital Forum, May/June 85

Mr. **Grandy**. Thank you, Ms. Thu. I am only going to ask one question of any of you ladies on the panel and then yield my time to Mr. Tauke who is the acknowledged leader and authority on health care, particularly rural health care. He also serves on the Energy and Commerce Committee and specializes in health care. So I would be more interested in hearing his questions than any ones that I could fashion.

I want to follow up on what the panel asked before.

Do you have any insight on what Alzheimer's is? For our own edification.

Ms. **McKay**. It is true, it is a very draining disease, not only, yes for the patient, but for the family, the person who has to take care of that Alzheimer's patient. We are seeing more and more of them in the northwest Iowa area and you just cannot imagine, I guess, the cost and the effort and the taxing on the family to take care of an Alzheimer's patient.

Mr. **Grandy**. But I guess I wanted to follow up a little bit on what Joe Bradley asked. It is a new term, at least to those of us who are not professional people. Where did that come from? Do you know? How long has it been called Alzheimer's disease? How long has it been in the public——

Ms. **Thu**. I would agree. It has been about 2 years that we've termed it Alzheimer's disease. But when I was working in the hospital, I'll never forget, one of the older physicians who had just been to a medical convention, said, "They are terming this thing that we called 'chronic, organic brain syndrome, or chronic brain syndrome,'" that then this person who dissected the brain and really went in to study the brain and the cells in the brain, that this person was, I suppose, Dr. Alzheimer, that it was after the person who discovered it.

Mr. **Grandy**. Thank you for putting that in the record. Tom.

Mr. **Tauke**. Well, thank you very much for some interesting testimony and we could talk all afternoon about problems of health care for senior citizens. Let me first just observe that it does seem to me that there is a reasonably good chance that we will change some of the rules relating to Medicare reimbursement for home health care in this Congress.

At least I am hoping that we will. Particularly home health care services that are offered in rural areas. Because we recognize that in many rural areas the reimbursement rules are even more devastating than they would be in the urban areas because of the nature of the care that needs to be offered.

Let me follow up on two other issues that you spoke about. First, the services provided by volunteers. You indicated to me that there is some concern about that. One of the things that has been talked about in relationship to the Older Americans Act is attempting to get volunteers to provide, maybe we wouldn't call them health services, but support services in the home. Could you talk about what you have in mind when we talk about volunteers.

Ms. **Lindstedt**. I certainly have nothing against the use of volunteers. What I would really hope for, however, is some kind of supervision or inclusion of those volunteers in a program that could provide supervision to them so that they can get their questions answered about how to deal with specific individual needs.

Certainly, volunteers can provide respite care. But that should be guided. I would be very concerned if they were out there on their own trying to deal with the needs of people that they are not really equipped to.

Mr. **Tauke**. Who can provide that kind of training? Suppose we say, okay, we have five volunteers in Algona, and golly, we need to give them some training. Where do we go.

Ms. **Lindstedt**. I think it is very feasible, and I have discussed that with another individual from our Area Agency on Aging, in regard to provision of respite services in particular, and it would seem to me that the Area Agencies on Aging might be able to contract with a service or agency that is providing in-home personal care services to provide some of that supervision and training.

Mr. **Tauke**. Clearly, one of the things that the Chairman Kildee, I think, has had in mind as he has talked about in-home services, is something that would fall short of what we would call health care services, it's chore services, some of these basic things to kind of keep you going. In the course of your work, do you find a need for that kind of assistance for the elderly, particularly those who might have some health-related problems?

Ms. **McKay**. You are speaking of the homemaker, home health services? Very much so.

So many of the elderly are not able to do their own laundry, go up and down the stairs, do their own grocery shopping, things like that that seem so routine to us but, yet, it can be devastating to them if they are in that home alone and don't have those services. A lot of the services that we do give is to keep that person safe and comfortable in their own home.

Mr. **Tauke**. I serve on the Committee on Aging and last year we had a hearing up in Michigan and I recall vividly the testimony of an individual who had been in the hospital, had had surgery, was released under the DRG in a weakened condition. And that individual said, "You know, I always did everything for myself, and I got home, and all my relatives are away, I got home and I found I couldn't do all these things that I always did." And the person started to deteriorate and ended up back in the hospital.

That is the kind of thing I think we are trying to prevent. You were going to comment?

Ms. **Thu**. Well, in our community we did run out of funds that went to the Chore Service and sometimes what we have to do is improvise. And we went to churches and asked if they would be willing to round up some volunteers to, you know, put on screens for some of the elderly in the summer or help winterize their houses in the winter. So, sometimes you do run out of those funds and the first priority seems to be personal care and then you've got to take away from some of those other areas. But they are necessary.

Mr. **Tauke**. The other issue that you have raised that I don't think that we've really talked about in relationship to this legislation, is health education.

Do we have health education for senior citizens in this area? And, if so, who is doing it?

Ms. **Lindstedt**. In Mason City, there are two hospitals, Community Hospital and Mercy Hospital, which is a system affiliated. Both of those institutions at the present time are providing what they call—each of them has titled them differently—but they are a senior outreach type of program. And both of them have the focus of educating the older person about basic care, self-monitoring, if you will, for health needs, as well as educating them about services, et cetera, that are available to them in the community.

Now, I don't know that all hospitals have that kind of thing. Many times those services are provided through—in local communities, to my knowledge, anyway—are provided through public health programs.

Ms. **Thu**. Yes, traditionally public health nurses have provided that. I am not sure if they—you know, I think they need to gear up again and really get in there to help educate more of the elderly towards the diseases that directly affect them.

Just recently, in our community, about two years ago we started a program of colo-rectal screening. And we went out to the Senior Citizens Center, a physician and myself, and it seemed at that point that the seniors were more interested in getting in to play bingo than they were to come to hear this really neat presentation on how to prevent colo-rectal cancer and one of the three detection tests that we were giving away free.

Now, this year I went out there and they put me in a different location. They chose a day when they had the best meal, they thought, it was chicken. They have great chicken in our area. But, anyway, they chose a day when they thought that most of the seniors would be there. They placed me right in front of hundreds of these senior citizens, and I handed out these little tests to them and I saw that some of them were kind of looking them over as I came in. So I started about a half hour early and we went over the true-false questionnaire and they had a few questions. Then I waited for all of them to come and I explained to them how to use this test. And then I went around from table to table and I'll bet, probably 70 percent—and I told them I didn't want them to take them unless they were motivated to do it—but I bet probably 70 percent of those seniors took this test. And part of it may have been that I did explain to them that last year when I did it, we had 36 people in our community that responded in a positive to a positive hemocult. And three of those were then diagnosed with cancer, two with pre-cancerous polyps, and, of course, you can use that President Reagan had it and that gives them a little energy to do it for themselves also. And we asked them to do themselves a favor.

So I think it is programs like that that we really need to get in there and help them to become motivated think of ways to prevent disease, and, if they do have a disease, what they can do, so that they can cope with it.

Mr. **Tauke**. Well, thank you, all three of you, very much for your testimony. It is very helpful

Mr. **Grandy**. Joe, did you want to ask something?

Mr. **Bradley**. Yes, please. What does the term respite mean?

Mr. **Grandy**. Let me ask for the record because I'm not sure they can hear you. What is the meaning of the term "respite," for the record?

Ms. **Thu**. It means relief for the care provider, and that care provider is usually a spouse or a family member who is exercising, delivering most of the care for a given individual.

Mr. **Bradley**. So it's really not caring for the patient. It is spelling off the person who has been caring for the patient.

Ms. **Thu**. Right. It is to give them some rest, some relief.

Mr. **Bradley**. What is the term used for the care of the terminally ill?

Mr. **Grandy**. Hospice.

Mr. **Bradley**. I don't follow that one, either.

Ms. **Thu**. It is a whole totally different program, and also there there is a Medicare benefit for hospice care. We are starting one of those in our area right now.

Mr. **Bradley**. Thank you very much.

Mr. **Grandy**. I want to thank you too, but before we adjourn, one question occurred to me while Mr. Tauke was questioning you, and that was, I would assume that as we expand in-home services, it will be necessary also to expand the ombudsman program to oversee some of those program.

As I'm sure you know, we presently have a program that requires state agencies to have a long-term health-care ombudsman. Do any of you have any feelings about the usefulness or effectiveness of that program? Have you had any connection with the ombudsman program?

Ms. **Lindstedt**. To my knowledge, the ombudsman program relates most directly to those individuals in nursing homes.

Mr. **Grandy**. That's correct.

Ms. **Lindstedt**. Not in home care.

Mr. **Grandy**. But I assume the contention is, if in-home services are expanded, it follows that there will probably be a need to have an ombudsman in this category as well.

I am wondering how you feel the ombudsman program works in the nuring home facility, in the nursing home setting.

Ms. **Lindstedt**. Variably, to my knowledge. I had been in another state 3 years ago, prior to coming to Iowa, and that was a very active program in Colorado. And it really, quite frankly, worked there variably depending upon the accountability that was built in.

Mr. **Grandy**. Do either of you ladies have any comments on ombudsmen?

Ms. **Thu**. No, I don't.

Ms. **McKay**. No, we don't have any comment.

Mr. **Grandy**. All right.

In that case I want to thank the three of you and I want to thank everybody who has participated in this hearing today, whether or not you have testified or simply been here to listen. I want to thank my colleague, Mr. Tauke, who came out here to participate and gather testimony. I want to thank Carol Lamb, his assistant, and, of course, Susan Wilhem, who is with Chairman Kildee, for appearing here and representing him.

Tom, do you have a closing statement? Is there anything that you'd like to conclude with?

Mr. **Tauke**. I just want to commend you for holding the hearing and join you in thanking the witnesses for their excellent testimony.

I'd also emphasize again that the record on this hearing will be open for two weeks, so if you have additional comments or thoughts, don't hesitate to send them to either of us and we will see that they are included in the record. And, even after that, of course, we are always available to listen to what you have to say relating to these issues.

Mr. GRANDY. Sherry, did you want to add one more thing?

Ms. THU. Yes, what would your address be?

Mr. GRANDY. Our address?

Ms. THU. Well, if we have something to add?

Mr. TAUKE. If you put "Congressman Tom Tauke" or "Congressman Fred Grandy, United States House of Representatives, Washington, D.C. 20515," you've got it.

Mr. GRANDY. And the number in New Jersey is——

[Laughter.]

Mr. TAUKE. We both have cards which we will leave with you if you'd like.

Mr. GRANDY. I have a closing statement which I am not going to read. I'll just submit it for the record.

I will say in closing, that the Older Americans Act is probably one of the most popular bipartisan supported pieces of legislation that comes out of Congress. And, as a result, it is a joy to work on a program like this that has both majority and minority support. And it is also a pleasure to work on this Committee with Mr. Tauke and Chairman Kildee who go a long way to making this program work.

I am glad that Algona could participate and I am sure that the testimony gathered at this hearing will be of enormous value when we mark up the bill in the weeks ahead.

So, thank you all.

[The closing statement of Hon. Fred Grandy follows:]

CLOSING STATEMENT OF HON. FRED GRANDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

I want to thank the witnesses who testified before us today for sharing their perspectives on the Older Americans Act and for offering their insights into innovative ways of improving the services provided under the act.

We have seen how the social services offered to our senior citizens has greatly improved their living standards and helped contribute to the physical, mental, and social well-being of those aged 60 and over. We need to applaud the area agency directors for their commitment to carrying out the goals and objectives of the Older Americans Act and at the same time, we look to these professionals for guidance in shaping the future of the programs designed to improve the lives of the elderly in our Iowa communities.

The testimony provided by Jean Beatty, Marvin Schlitzer, Sonia Crow, and John Merz indicated that the nutrition program has been a highly successful service for senior citizens and one that has truly filled a void in ensuring that the nutritional needs of this group is well served. At the same time, we need to continue exploring innovative ways of using surplus agricultural commodities. Increasing the use of these commodities help meet the objectives of providing nutritious meals for the elderly while helping farmers by alleviating surplus agricultural commodities.

Health care for the elderly is a growing concern which needs to be addressed before we reach a crisis which threatens the well-being of our senior citizens if not addressed in a comprehensive and timely manner. The growing cost of institutional care forces us, again, to develop new approaches to providing care. By making in-home health service delivery available to those who are then able to stay in their homes, we reduce health care costs for all. We need to accurately project what our needs will be and plan accordingly so that the goals stated in 1965 when the act was passed truly allow senior citizens to manage their own lives to the fullest extend possible.

The testimony we heard today provides clear evidence that the Older Americans Act is a vital program which serves our elderly well. We need to build on our own success by continuing to respond to the needs of our senior citizens in each of our communities.

Again, I want to thank our panelists for their testimony and thank you, the people of the sixth district, for coming. The information we shared today has been most helpful.

Thank you.

Mr. GRANDY. And, we are adjourned.

[Whereupon, at 3 p.m. the subcommittee hearing was adjourned.]

[Additional material submitted for the record follows:]

STATE OF
IOWA
TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF ELDER AFFAIRS
~~KAREN L. TYNES, EXECUTIVE DIRECTOR~~
Ronald W. Beane, Acting Executive Direct

May 5, 1987

Congressman Fred Grandy
United States House of Representatives
Washington, D.C. 20515

IN RE: For submittal to the record of the hearing before the Subcommittee on Human Resources regarding the 1987 reauthorization of the Older Americans Act

Congressman Fred Grandy:

This is in response to requests for information and other questions raised as your Subcommittee's recent hearing regarding the reauthorization of the Older Americans Act in Algona, Iowa.

First of all, a question was raised regarding the number of OAA Title V job slots currently allocated to Iowa. Our records indicate that for the upcoming state program year, July 1, 1987 through June 30, 1988, Iowa will be allocated 836 Title V OAA employment positions at a projected expenditure of $4,270,553.00 For the program year July 1, 1986 through June 30, 1987, Iowa has 789 Title V OAA employment positions with a projected expenditure of $4,030,462.12.

Employment specialists with the State of Iowa Department of Elder Affairs indicate that effort to implement a substandard minimum wage for the Title V positions should be vigorously opposed as relegating the Title V program to second class employment which is contrary to the whole intent of the program.

With regard to the question which arose at the hearing regarding a "set aside" for legal assistance provided to elders under the OAA. As I stated at the hearing in Algona, Iowa, I have a firm belief that given existing resources and service requirements, the local area agencies on aging are in the best position to determine the distribution of funds amongst the required Title III services. However, if new funding were

236 JEWETT BUILDING / 914 GRAND AVENUE / DES MOINES, IOWA 50319 / 515 281 5187

allocated specifically for legal assistance, I would be in favor of "a "set aside" in that sense. Legal assistance is a vital service for Iowa's and the Nation's elders. New funding for legal assistance would be well spent. However to "set aside" a dollar amount for legal assistance from the existing pool of Title III funding would cause unnecessary disruption of service at the local level.

Thank you for the opportunity to comment.

Sincerely,

Vince Weber

Vince Weber
Legal Services Developer

VW:pak

Swiss Valley
FARMS

April 22, 1987

TO: Congressman Fred Grandy
Congressman Thomas Tauke

RE: Hearing on April 24, 1987 at Algona, Iowa.

Dear Congressman Grandy and Tauke:

Since I will be unable to attend the hearing in Algona on April 24 where you plan to receive comments on the Older Americans Act of 1965, I respectfully request to place a statement in the Congregational record.

Swiss Valley Farms is an agricultural cooperative owned by approximately 4,000 farmers in the Upper Midwest. We are processors and distributors of dairy products and, on occasion, sell products to the Commodity Credit Corporation during periods of heavy surplus.

All of the products which we sell to CCC are of excellent quality when they leave our plants. The grading by CCC is at a considerably higher standard than that for the industry in general so we are well acquainted with the standards of quality and the demands of the CCC for excellence in product quality.

Over the years, we have observed that many of the dairy commodities purchased by CCC are held in storage for many months before being distributed, or before finally going out of condition. In our opinion, these products should be moved to the various feeding programs, particularly the Elderly Nutrition Program as most of these products can be utilized in that manner. While our feeding programs might not utilize 100 percent of the product, there is a great deal of it that could be utilized at a considerable savings to the taxpayers.

We believe that such a distribution program makes sense for the following reasons:

1. The government will save a considerable amount of money on the storage of product.
2. If the product is put into good use, the government will not need to pay interest on the money which is used to pay for the commodities as they would be distributed promptly.
3. The government would also save money which is now being spent to buy food which is presently available from CCC.
4. For every pound of product which would be used promptly in the feeding program, taxpayers would save on the loss of product which would go out of condition while in storage.

Swiss Valley Farms, Co. / P.O. Box 4493 / Davenport, IA 52808 / 319 391-3341

April 22, 1987
Page 2

We sincerely believe that it is in the mutual best interest of taxpayers, the elderly involved in feeding programs, and farmers to move on a distribution of these commodities within the programs which are administered by the Older Americans Act.

We respectfully request that you do everything possible to implement the increased use of agricultural commodities by the elderly nutrition program which is a part of the Older Americans Act.

If we can work with you in supplying any other information, please feel welcome to call upon us.

Very truly yours,

SWISS VALLEY FARMS, CO.

Carl E. Zurborg
Chief Executive Officer

CEZ:njk

Spencer Municipal Hospital

114 East 12th Street Spencer, Iowa 51301-4330 Telephone 712-264-6198

APRIL 29, 1987

The Honorable Tom Tauke
Second District
2244 Rayburn Bldg.
Washington, D.C. 20515

Dear Mr. Tauke,

I would like to submit the attached information regarding Alzheimer's Disease to my testimonial on April 24, 1987. I particiated on the subcommittee on Human Resources, Algona Public Library, Algona, Iowa.

Sincerely,

Sheryl Thu, RN

Sheryl Thu, R.N.

Enc.

ST/sl

Alzheimer's Disease was named in 1906 when a German physician, Alois Alzheimer, described the condition.

Alzheimer's Disease
and Related Disorders Association, Inc.

70 EAST LAKE STREET CHICAGO, ILLINOIS 60601 NATIONAL HEADQUARTERS

FACT SHEET ON ALZHEIMER'S DISEASE

DEFINITION AND SCOPE: Alzheimer's disease is a progressive, irreversible neurological disorder that affects an estimated 2.5 million American adults. It is the most common form of dementing illness. Alzheimer's disease causes 100,000 deaths annually, and is the fourth leading cause of death in adults, after heart disease, cancer and stroke.

The disease knows no social or economic boundaries and affects men and women almost equally. Most victims are over 65, however, Alzheimer's disease can strike in the 40s and 50s. Most Alzheimer's disease victims are cared for at home, although many persons in nursing homes have dementia. Alzheimer's disease is devastating for both victims and their families and has been called "the disease of the century."

SYMPTOMS: Symptoms of Alzheimer's disease include a gradual memory loss, decline in ability to perform routine tasks, impairment of judgment, disorientation, personality change, difficulty in learning, and loss of language skills. There is variation in the rate of change from person to person. In most cases, the disease will eventually render its victims totally incapable of caring for themselves.

CAUSE(S) & RESEARCH: The cause of Alzheimer's disease is not known and is currently receiving intensive scientific investigation. Suspected causes include: (1) a slow virus or other infectious agent; (2) a genetic predisposition; (3) environmental toxins such as aluminum; (4) immunologic changes; or other factors.

Scientists are applying the newest knowledge and research techniques in histology, virology, immunology, toxicology, neurology, psychiatry, pharmacology, biochemistry, molecular genetics and epidemiology to find the cause, treatment, and a cure for Alzheimer's disease and related dementias.

DIAGNOSIS: There is no single clinical test to identify Alzheimer's disease. Before diagnosis of the disease is made, other potentially reversible conditions must be excluded. These include depression, adverse drug reactions, metabolic changes, nutritional deficiencies and head injuries.

Each person with possible Alzheimer's disease symptoms should have a thorough evaluation. Recommended tests include physical, neurological, psychological and psychiatric examinations, laboratory studies include blood studies, computerized tomography (CT scan), electro-encephalography (EEG) and occasionally studies of the spinal fluid. While this evaluation may provide a clinical diagnosis, confirmation of Alzheimer's disease requires examination of brain tissue, which is usually performed at autopsy.

TREATMENT: Although no cure for Alzheimer's disease is available at present, good planning and medical and social management can ease the burdens on the patient and family. Appropriate medication can lessen agitation, anxiety and unpredictable behavior, improve sleeping patterns and treat depression. Physical exercise and social activity are important, as are proper nutrition and health maintenance. A calm and well-structured environment may help the afflicted person to maintain as much comfort and dignity as possible.

ECONOMIC IMPACT: The course of the disease is usually several years, some of which may require total care regarding daily activities such as eating, grooming and toileting. It is estimated that more than $34 billion is spent annually on the costs of caring for Alzheimer's disease victims both in nursing homes and at home.

ADRDA: The Alzheimer's Disease and Related Disorders Association (ADRDA), founded in 1980, is a privately-funded national voluntary health organization. Headquartered in Chicago, ADRDA has more than 500 support groups and over 125 chapters nationwide. ADRDA's board of directors is comprised of business leaders, health professionals, and family members. Additionally, there is a prestigious Medical and Scientific Advisory Board which consults and monitors issues related to Alzheimer's disease.

ADRDA has four major goals: (1) Supporting **research** into causes, treatment, cures and prevention; (2) Providing **family support** through local chapters and family support groups which provide assistance to afflicted families; (3) Stimulating **education and public awareness** for both laymen and professionals on Alzheimer's disease; (4) **Advocacy**, encouraging legislation that responds to the needs of Alzheimer's disease patients and family members, at federal, state and local levels. The national office promotes public awareness; maintains liaisons with government agencies and national professional organizations; stimulates family support activities; administers a research grant program to initiate new investigations into the cause(s), prevention and cure of Alzheimer's disease; serves as a clearinghouse for information; and publishes a quarterly newsletter. ADRDA sponsors a month-long public awareness campaign for National Alzheimer's Disease Awareness Month each November.

Alzheimer's Disease International was formed in 1984 to share program and research developments on Alzheimer's disease worldwide.

HOTLINE: A nationwide 24-hour hotline provides information and links families who need assistance with nearby chapters and affiliates. Those interested in help may call **800-621-0379.** (Illinois residents, call **800-572-6037.**) The telephone number for the national office in Chicago is **312-853-3060.**

MEANS TESTING: A CONCEPT WORTHY OF CONSIDERATION

BY DICK AMBROSIUS

At the Annual Meeting of the American Society on Aging held recently in Salt Lake City, I was called upon to debate Bob Blancato, U.S. House Select Committee on Aging Staff, on the topic of whether or not the Older Americans Act should be "means tested." I was given the task of supporting means testing. Throughout the two hour session, both debaters and panelists seemed to reach a consensus that some type of "means testing" or "cost sharing" will become a necessity to providers of aging services.

As "means testing" is debated during the re-authorization process, no doubt, Congressional intent will be used as an argument against the concept. The people using this argument usually do so with the serene confidence of a Christian...who's holding four aces. In the following paragraphs, the case is made for considering new and innovative options to aging service delivery, with the "intent" of moving toward more accountability and self sufficiency.

Until the 1984 amendments, the word "contribution" or "donation" never appeared in the law. In fact, the law always said that organizations would charge for services under the act in accordance with regulations promulgated by the Commissioner. Now, if anything is a violation of "congressional intent", it would appear that regulations which said "contribute" when the law said "charge" may have been a violation of that intent.

The mere phrase "in violation of congressional intent" has always bothered me. I think we can assume the all congressmen and senators have the ability to both read and write. So why can't they just write what they want to say instead of telling us at some point in the future what they "intended" to say. Well, when I was in college, I always intended to get A"s on my math tests; but I also discovered that the argument of "student intent" carried very little weight with my professors.

After conducting training and consulting visits to aging organizations in 46 of our 50 states, I have concluded that the effectiveness of aging programs has very little to do with regulatory language or enabling legislation. As Charles Peters observed in his book, HOW WASHINGTON REALLY WORKS, "the present system of government is designed to protect those within it, not serve those outside it." Isn't it time we began putting the welfare of the nation's older people above winning the next election; protecting the status quo or rewarding special interests.

I'm sure many remember the charges and counter charges leveled during the last re-authorization of the act. The criticism was that any effort to increase program income from Title III programs would result in declining participation. These charges were issued with more than a little emotion and backed up with no facts whatsoever. Well, participation is dropping, so were the critics right? No! It's time we realized that the one ailment antibiotics will never stamp out is the premature formation of opinion.

As we look to the future needs of older persons, not just the low income and disenfranchised, but all older persons, there are some basic questions we need to answer which haven't been asked much:

- Do we know who current participants are?
- Do we know their needs, their wants, their expectations or are we building a program based on staff perceptions of needs without researching or communicating with the consumers?
- Do we know where participation is dropping and why?

It is time we began applying positive client relations, efficiency, cost control, and treat every new person coming into the program as if they were the most important person to ever walk through the front door. Customer relations research has pointed out time and time again that a satisfied customer, (and the people who participate in Aging Programs are your customers) will tell five other people. The unhappy customer will tell 15. If we are not making participants happy, the decline in participation is our fault; and we must stop blaming some "regulatory language". Regulations don't make programs successful, people do. We are all "self made", but only the successful will admit it. We must gain a greater appreciation for the customer and what they're willing and able to do.

Now, whichever side of this argument you take, you can find any number of supporting statistics. For example, a recent article emanating from Washington wire reports, carried the headline, "Study: Millions of Elderly Poor at Risk." Now this news story went on to relate that these conclusions were drawn from a foundation study in relation to the elderly poor. The conclusion was based on the fact that "3.5 million to 4.2 million Americans (give or take a million) over age 65 live below the poverty line. Another 8 million 'teeter just' on the edge, with earnings less than double the poverty level."

Well, I teeter just below financial stability with earnings less than double what they should be. The"risk" the article went on, comes from the fact that "average out-of-pocket health care costs for the elderly accounted for 15% of their income in 1984, about the same as before medicare was enacted in 1965." What it didn't go on to point out was whether the remaining 85% of income was discretionary; or that 80% of older people own their homes and the vast majority of those homes are owned free and clear; or that the non-elderly are spending 30% of their income out of pocket for housing expenses. We must stop making sweeping conclusions with no more that a trifling of fact.

This is not to argue that low income older people do not have critical needs...they do. If even one person living below the poverty level is driven from a meal site or any other program because of an inability to pay for that service, we are violating both the letter and spirit of the law! However, we should also not ignore the market reality. Over 80% of older people are not below poverty; are in need of services and willing to pay for them. The private sector is responding, but not the Aging Network. It has tied its own hands. I've heard agencies say, "sure we could generate more revenue; but we can't charge for anything."

We must stop referring to the problems of aging and start serving older people who have problems. Aging is not a problem...poverty is a problem....poor health is a problem...discrimination is a problem....not aging.

I'm amazed when people say that any attempt to means test the Older Americans Act would kill the program. Of course, this is just as technology destroyed business.

When someone makes a statement about any new concept and begins by stating, "that will never work," I go the the crystal ball department to check on similar doom forecasters. For example:

> "Heavier that air flying machines are impossible," from Lord Kelvin, President of the Royal Society.
>
> "Everything that can be invented has been invented," from Charles H. Duell, Director of the U.S. Patent Office, 1899.
>
> "Sensible and responsible women do not want to vote," from Grover Cleveland in 1905.
>
> "There's no likelihood man can ever tap the power of the atom," from Robert Millikan, Nobel Laureate in Physics, 1923.
>
> "Who the hell wants to hear actors talk?" from Harry M. Warner, Warner Brothers Pictures, 1927.

The only way to be sure something won't work is not to try it. Let's challenge the people making sweeping conclusions about the impact of increased flexibility and local control of services. Sweeping conclusions made with a marginal trifling in fact are the threat to the future of the Aging Network.

If we continue to operate Older Americans Act Programs as we have in the past, we will have become processionary caterpillars, blindly following habit. We must realize that the elder market is not homogenous, but an ever-changing, dynamic, exciting market segment. Yes. participation is dropping throughout the United States. Participation is dropping because of negative attitudes, bureaucratic protection of the misfeasant, decisions based on political convenience rather than hard data, and negative regulatory incentives. When I was in Washington, D.C. last year, I talked to several staff who were hesitant to release the results of a 2-1/2 year study by Phoenix Systems, because it would contradict current perceptions: "That low income or minority participation was dropping due to increased emphasis on contributions." When I asked exactly where participation was dropping and if anyone knew specifically why it was dropping in certain areas, or if the problem was isolated, no one could answer my questions. Isn't it time we develop some market research to determine what the customers need, want, and are willing and able to pay for; and make sure we understand each situation before we react. What you think seems to depend considerably on where you sit, not what you know.

In a country that was built on a foundation of competition, we have eliminated competition from human services. Now, competition doesn't create character; but it does expose it. To support my position that a means test alone would not result in a dramatic participation drop, consider the results of a Phoenix Systems' study conducted over 2-1/2 years from 82-85. We received surveys from 18,895 older participants at congregate meals programs at 30 locations in 20 states. Of those completing the surveys, 96.3% said that their donation was voluntary. We did not find any case where pressure to contribute was a significant problem. Where it was a slight problem, it was isolated at 1 or 2 sites and due to staff, not policy. 27.3% did know someone who had stopped attending; but the reasons for this decrease was poor health, #1; poor food, #2; lack of transportation, #3; dislike of other participants, #4; dislike of staff, #5; lack of money, #6; no activities, #7; and the last was pressure to contribute, which was 3% of the respondents who knew someone.

What was considered a fair and affordable contribution for the service? 83% said $1.00 or more and 23% said $1.50 or more. Now that is considerably higher than the national average. Further, 1 in 10 said they would give more if the quality and variety of the food improved. Two thirds were not even aware of the actual cost of the food and 67.4% had never heard of the Older Americans Act.

Now, some people have challenged our results claiming they were somehow politically motivated. A strategy that seems to work when research documents something you don't want to know. However, the results of a similar survey taken last year in suburban Cook county, Illinois reinforces our study. 229 current nutrition participants were interviewed; 49 participants who had stopped attending; and 45 potential participants.

The interesting part of this study is that it provided an opportunity to compare perceptions to reality. In other words, of those who were responding to why they thought other people had quit was compared to the actual reasons given by those who had stopped attending. The perception was that most had stopped attending because of poor food, while the reality was poor health. Further, comparisons were more eye opening; (the first percentage being perceived, the second the actual): 24% poor food, actual 18%; poor health, 73%, actual 39%; 5% lack of transportation, actual 16%; 4% attending another site, actual 6%; 4% that it was too expensive, actual 2%, which incidentally ranked equally to being bored and feeling unwelcome. Finally, and the second largest actual reason given for quitting and one which did not even appear in the perceptions; 24% said they were simply too busy to attend. And 4% didn't like the other participants.

The Cook County study further documented that 78% of those participating said their donation was voluntary and most considered $1.00 or more to be both fair and affordable. This incidentally was regardless of income. 45% thought that more minority targeting should be done by staff; and we strongly concur.

Now to the question, "To means test or not", let's look at the proposals currently being considered. One is that below a certain income level, the program is free and above a certain level, it's denied. Thereby, this recommendation eliminates 86% of the potential market and a large source of revenue for ongoing program development, expansion, and targeting to those most in need. Anyone supporting this option has a programmatic death wish and lacks any sense of marketing reality. A second is that below a certain income level, programs are free and above, we adopt a sliding fee schedule. My concern is that this establishes a class system and a ghetto mentality. It's a disincentive which ignores the need for individual dignity and self-esteem which are held high by most older persons. In my experience, low income locations often have the highest average donations.

The Act keeps changing, it appears, to protect turf and perpetuate jobs; but what about the needs of the older people? The customer? What do they want? What are they willing to do to make this program a success? Why don't we just tell them what we need to operate and set a schedule accordingly?

So let's "mean test" the act, but in a manner which increase success potential. Let's test a sliding fee schedule on an honor system, directed at achieving an average minimum contribution necessary for program operations for 12 months. Provide older people who are intelligent, rational, pragmatic persons the opportunity to achieve their own success before we attempt to legislate it. But at the same time, provide those involved in day-to-day operation with the authority they need to achieve success; and implement a local "test" tailored to local needs.

For those programs where there is a high need and income is even more a factor, such as home health services, let each service provider adopt a sliding fee schedule which relates to their cost of operation, their constituent population, and financial resources.

Why don't we realize that some bureaucratically or politically inspired standard simply won't work, and never has. So let's adopt a means test, but let's make it a local option. I don't mean state option, I mean local option. The administrators who are best qualified to make this decision are those who work day-to-day with the customer...the provider...not the regulation writers or desk bound planners.

While we're at it, let's change the allocation formula too. Why award funds based on population density with no relation to service provision? The nutrition program would be a good place to start...provide funds based on meals served. It's never made any sense to distribute a huge sum of money based on the number of the older people who happen to live in a particular state, region or community. That method of awarding funds has nothing to do with service, productivity or need.

The providers of services to older Americans are entering an exciting and demanding era. The market will become increasingly diverse and segmented with new opportunities appearing constantly. To survive in a competitive market, service providers must be afforded increased flexibility and positive regulatory incentives. The "we were here first" or "they can't do that" mentality could become the Network's epitaph. It is time to consider the future of aging programs in a realistic discussion based on fact, not perception and emotion.

Providing for "means testing", "cost sharing" or whatever bureaucratic "buzz word" the marketing option is labeled, must be accompanied with the flexibility necessary for success. Attempting to set a restrictive national standard supported by mandates and stacks of new reports will only compound the frustration many nonprofits are already experiencing.

To the regulation writers and the policy makers, I offer the words of Fats Waller, "If you don't know what it is, don't mess with it!"

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